HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
DECEMBER 18, 2013
APPLICATION SUMMARY

NAME OF PROJECT: Vanderbilt University Hospitals

PROJECT NUMBER: CN1309-034

ADDRESS: 1211 Medical Center Drive
Nashville (Davidson County), Tennessee 37232

LEGAL OWNER: Vanderbilt University Hospitals
1211 Medical Center Drive
Nashville (Davidson County), Tennessee 37232

OPERATING ENTITY: Not Applicable

CONTACT PERSON: Ron W. Hill
(615) 936-6012

DATE FILED: September 13, 2013

PROJECT COST: $7,535,709

FINANCING: Cash Reserves

PURPOSE OF REVIEW: Hospital Renovation in Excess of $5 Million

DESCRIPTION:

Vanderbilt University Hospitals is seeking approval for the expansion and renovation of the hospital's existing third floor operating suite, adding four operating rooms and providing shell space for future expansion of two additional operating rooms at 1211 Medical Center Drive, Nashville (Davidson County), TN.

CRITERIA AND STANDARDS REVIEW

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

2. **For renovation or expansions of an existing licensed health care institution:**

   a. **The applicant should demonstrate that there is an acceptable existing demand for the proposed project.**

      Vanderbilt University Hospitals (VUH) expects surgical volumes to increase 25% from an estimated 30,645 adult surgical cases in FY2013, to a projected surgical volume of 38,600 surgical cases in FY2017. One of the factors increasing VUH surgical volumes is the relocation of Nashville Surgery Center case volume to the VUH campus in October 2014, resulting in an estimated 3,000 additional cases.

      It appears that the application meets this criterion.

   b. **The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.**

      The proposed project is adjacent to the existing surgical service and will improve patient flow, expand operating room capacity and the coordination of patient care.

      It appears that the application meets this criterion.

Staff Summary

The following information is a summary of the original application and all supplemental responses. Any staff comments or notes, if applicable, will be in bold italics.

The proposed project will consist of the expansion and renovation to the existing third floor forty-six (46) operating room suite by the addition of four operating rooms and by providing shell space for future expansion of two additional operating rooms.

Currently

- There are a total of sixty-eight (68) operating rooms at Vanderbilt University Hospitals, fifty (50) adult and eighteen (18) children at Monroe Carell Jr. Children's Hospital at Vanderbilt.
- VUH's fifty (50) adult ORs currently utilizes 83.3% of available schedule OR time. There is also one (1) additional OR typically used for highly specialized interventional brochoscopic surgeries that uses 65.1% of scheduled OR time.
- There are currently forty-six (46) adult ORs on the third floor of VUH, three (3) ORs in the Free Electron Laser On-Campus Center, and one (1) hybrid OR on the first floor of VUH.
- The VUH operating rooms vary from approximately 400 to approximately 1,200 SF per room.
- All surgical suites are open from 7:00 am to 5 pm or 7:00 pm, depending on the specialty, Monday through Friday, as well as a subset of ORs that are open 24/7/365 days per year.

Proposed

- The four ORs will be located adjacent to existing surgical suites on the 3rd floor. This project also includes shelled-in space for two future ORs.
- The project includes approximately 9,108 square feet of renovated space.
- The four ORs will range from 595 SF to 616 SF.
- Shelled space will represent 2,739 SF, clean core 1,189 SF, and support space 902 SF.

Need

- The additional four ORs will provide additional capacity for surgical weight loss interventions and joint replacement surgery.
- Growth on surgical specialties will require distribution of the new cases among many operating rooms.

- The last three years VUH has experienced a 3% growth rate for inpatient cases and 12% for outpatient cases.

An overview of the project is provided on page 4 of the original application.

The applicant seeks to begin the use of the new surgical suite in November 2014.

Ownership
Vanderbilt University, by and through its Vanderbilt Medical Center, owns Vanderbilt University Hospital facilities. An organizational chart is included in Attachment A.4.

Facility Information

- VUH is a level I trauma center as well as a safety net hospital which reports providing over $370 million to indigent and uninsured populations
- The four room surgery suite will be on the third floor of VUH. A floor plan drawing is included in Attachment B.IV.
- VUH is a 985 licensed bed acute care hospital. The Joint Annual Report for 2012 indicates VUH staffs 966 beds. Licensed bed occupancy was 76.5% and staffed bed occupancy was 78%.

The following provides the Department of Health's definition of the two bed categories pertaining to occupancy information provided in the Joint Annual Reports:

- *Licensed Beds - The maximum number of beds authorized by the appropriate state licensing (certifying) agency or regulated by a federal agency. This figure is broken down into adult and pediatric beds and licensed bassinets (neonatal intensive or intermediate care bassinets).*
- *Staffed Beds - The total number of adult and pediatric beds set up, staffed and in use at the end of the reporting period. This number should be less than or equal to the number of licensed beds.*

Service Area Demographics
VUH's declared service area includes:

Tennessee Counties
Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Fentress, Franklin, Giles, Grundy, Hickman, Houston, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Stewart,

Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, and Wilson Counties.

- The total population of the Tennessee service area is estimated at 2,615,771 residents in calendar year (CY) 2013 increasing by approximately 5.5% to 2,760,336 residents in CY 2017.
- The overall Tennessee statewide population is projected to grow by 3.7% from 2013 to 2017.
- The latest 2013 percentage of the proposed primary service area population enrolled in the TennCare program is approximately 15.8% in the service area as compared to the statewide enrollment proportion of 18.4%.

Kentucky Counties

Allen, Ballard, Butler, Caldwell, Calloway, Carlisle, Christian, Crittenden, Daviess, Edmonson, Fulton, Graves, Henderson, Hickman, Hopkins, Livingston, Logan, Lyon, Marshall, McCracken, McLean, Monroe, Muhlenberg, Ohio, Simpson, Todd, Trigg, Union, Warren, and Webster Counties.

Source: The University of Tennessee Center for Business and Economic Research Population Projection Data Files, Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics.

Service Area Historical Utilization

	Inpatient				Outpatient		
	Encounters	**#ORs**	**Procedures**		**Encounters**	**#ORs**	**Procedures**
2009	83,430	334	153,550		121,117	50	168,482
2010	83,223	335	164,074		126,792	49	171,815
2011	87,050	354	162,012		131,144	45	183,356
2012	90,427	351	163,910		143,737	50	199,698
09-12 % Change	**+8.4%**	**+5.1%**	**+6.7%**		**+18.7%**	**0.0%**	**+18.5%**

Source: 2009-12 Hospital JARs

Vanderbilt Historical Utilization

	Inpatient			Outpatient		
	Encounters	#ORs	Procedures	Encounters	#ORs	Procedures
2009	21,283	54	40,462	18,597	3	30,627
2010	21,633	61	43,346	23,674	6	39,399
2011	22,242	62	46,436	25,631	5	43,705
2012	22,140	62	46,443	28,604	6	49,481
09-12 % Change	**+4.0%**	**+14.8%**	**+14.8%**	**+53.8%**	**+100.0%**	**+61.6%**

Source: 2009-12 Hospital JARs

- The charts above indicate that both inpatient and outpatient hospital surgery volumes are increasing; however outpatient volumes are increasing over double the rate of inpatient volumes.
- Vanderbilt has experienced moderate increase in inpatient surgery encounters between 2009 and 2012 (4.0%). Outpatient surgery encounters have increased over 53% during the same time period.

Applicant's Historical and Projected Utilization

The applicant also provides historical and projected surgical case volumes by specialty. Historic and projected trends are displayed in the table below.

	2010	2011	2012	2013	2016	2017	'10-'17 % Change
***VUH Cases**	31,284	32,895	34,969	35,947	37,586	38,606	**+23.4%**
Projected Utilization-Proposed 4 ORs					2,675	2,729	
Proposed 4 ORs Percent of Total					7.1%	7.06%	

Vanderbilt surgical case volume currently performed at Nashville Surgery Center (NSC) will be relocated to VUH in October 2014 resulting in approximately 3,000 additional cases VUH cases include NSH volumes. Source: CN1309-034

- The table above indicates the projected cases of 2,675 in Year One and 2,729 in Year Two represents 7.1% and 7.06% of all VUH Surgical Case Volume.
- The applicant projects that the surgical case volumes in 2017 will be over 23% greater than the case volume in 2010.

- On page 12 of the first supplemental response the applicant includes a chart that indicates that the operating rooms at VUH are scheduled with surgery cases over 83% of available time.

  The chart below provides the top ten specialty mix at VUH by cases reported for FY 2013.

Specialty	FY 2013 Cases	% Total	Cum. %
Orthopedics	5,523	16.8%	16.8%
Urology	3,551	10.8%	27.6%
ENT	3,504	10.6%	38.2%
Neurosurgery	2,839	8.6%	46.8%
General	2,439	7.4%	54.2%
Surg.Oncol.	2,302	7.0%	61.2%
GYN	2,114	6.4%	67.6%
Trauma	1,891	5.7%	73.3%
Plastic	1,835	5.5%	78.8%
Cardiac	1,274	3.9%	82.7%
Other	18,675	17.3%	100.0%

Source: CN1309-034

- The top specialty is Orthopedics and accounts for almost 17% of surgical volume.
- The top five specialties account for over half the surgical volume.
- The top ten specialties account for over 80% of the surgical volume.

Project Cost

Major costs are:

- Construction Costs plus contingencies- $4,346,482 or 57.7% of total cost.
- Fixed and moveable equipment- $2,820,827, or 37.4% of the total cost.
- Average renovation cost is expected to be $475.00 per square foot. The third quartile for cost per square foot of previously approved hospital projects from 2010-2012 was $249.00. The applicant states that the reasons for the higher cost include higher constructions costs for surgical facilities and mechanical requirements.
- For other details on Project Cost, see the Project Cost Chart on page 13 of the original application.

Historical Data Chart

- According to the Historical Data Chart VUH experienced profitable net operating results for the three most recent years reported: $91,282,396 for 2010; $102,795,178 for 2011; and $104,181,348 for 2012.
- Average annual Net Operating Income (NOI) was favorable at approximately 9.3% of annual net operating revenue for the year 2012.

Projected Data Chart

- 2,675 cases are projected in Year 2016 and 2,729 cases in Year 2017.
- Net operating income less capital expenditures for the proposed project will equal $3,211,343 in Year 2016 increasing to $3,287,273 in Year 2017.

Charges

In Year One of the proposed project, the average charge per case is as follows:

Average Gross Charge
- $40,294

Average Deduction from Operating Revenue
- $29,286

Average Net Charge
- $11,008

Medicare/TennCare Payor Mix

- TennCare/Medicaid-Charges for VUH will equal $7,545,137 in Year One representing 7% of total gross revenue.
- Medicare- Charges will equal $43,115,069 in Year One representing 40% of total gross revenue.

Financing

An August 21, 2013, letter from Karen Nanney, Vanderbilt University Medical Center's Interim Senior Vice President of Finance, confirms the applicant has sufficient cash reserves to finance the proposed project.

Vanderbilt Universities' audited financial statements for the period ending June 30, 2012 indicates $912,419,000 in cash and cash equivalents, total current assets of $1,999,157,000 (daily redemption), total current liabilities of $315,577,000 and a current ratio of 6.33:1.

Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

Staffing

The applicant's proposed changes in direct patient staffing due to the proposed project are presented in the table below:

Position	Proposed
Registered Nurse	9.4
Surgical Technicians	5.6
RN Facility Administrator	2.0
Total	**17.0**

Licensure/Accreditation
VUH is licensed by the Tennessee Department of Health, Division of Health Care Facilities.

VUH is accredited by The Joint Commission with an accreditation cycle effective July 28, 2012 valid for up to thirty-six (36) months. A report from The Joint Commission dated September 24, 2012 is included in Attachment C., Contribution to the Orderly Development of Healthcare.7.d.

Corporate documentation, real estate deed information, performance improvement plan, utilization review plan, and patient bill of rights are on file at the Agency office and will be available at the Agency meeting.

Should the Agency vote to approve this project, the CON would expire in **three** years.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT
There are no Letters of Intent, pending or denied applications for this applicant.

Outstanding Certificates of Need

Vanderbilt University Hospital, CN0606-037A, has an outstanding Certificate of Need that will expire on July 1, 2015. The Certificate of Need was approved at the September 27, 2006 Agency meeting to renovate 77,120 square feet of existing space and to construct 307,470 square feet of new space, the centerpiece of which is a ten story bed tower, which will be placed between the existing VUH building and The Vanderbilt Clinic (TVC). The proposed project includes the addition of one hundred forty-one (141) acute care beds including the conversion of an existing skilled nursing unit to acute care beds, the relocation and expansion of cardiac catheterization services, the relocation of a clinical research unit, and the net increase of twelve operating suites. *Project Status: According to a December 9, 2013 email from a Vanderbilt representative, the project continues with completion of the fifth floor catheterization lab anticipated for a mid-January completion and Licensure survey. Additional work on one half of the second floor and associated relocations of services remain. All bed floors have been completed and are in service.* The estimated project cost is **$234,421,471.00**

Monroe Carell Jr. Children's Hospital at Vanderbilt, CN0710-075A, has an outstanding Certificate of Need that will expire on March 1, 2014. The Certificate of Need was approved at the January 23, 2008 Agency meeting to expand the existing Monroe Carell Jr. Children's Hospital (MCJCH) through an adjacent building connected to the existing hospital. The expansion will provide 90 additional pediatric acute critical care beds, 26 neonatal intensive care beds (16 relocated), and an expanded obstetrical service including 36 relocated postpartum beds, 12 new antepartum beds, 16 labor and delivery suites (12 relocated), 2 relocated operating rooms and 1 new obstetric operating room. Five pediatric operating rooms are proposed on the third floor which will also contain 5 additional shelled operating rooms to accommodate continued growth. MCJCH is not licensed separately from Vanderbilt University Hospital (VUH). VUH's licensed bed capacity will increase from 946 to 1,051. *Project Status: According to a December 9, 2013 email from a Vanderbilt representative, the 33 bed modification is complete and the beds are in service. Accommodations to achieve the total approved 1,051 beds are under consideration.* The estimated project cost is **$248,326,286.00**.

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:

There are no other Letters of Intent or denied applications for other health care organizations proposing this type of service.

Pending Applications

Seton Corporation d/b/a Saint Thomas Midtown Hospital f/k/a Baptist Hospital, CN1307-028, has a pending application scheduled to be heard at the Agency's December 18, 2013 meeting. The proposed project is for the modification of the hospital by replacing and relocating four (4) operating rooms. The estimated project cost is **$11,499,496.00**.

Outstanding Certificates of Need:

Baptist Plaza Surgicare, CN1307-029A, has an outstanding Certificate of Need, which will expire on December 1, 2016. The project was approved at the October 23, 2013 agency meeting for the relocation and replacement of the existing ASTC from 2011 Church Street Medical Plaza I Lower Level, Nashville (Davidson County) to the northeast corner of the intersection of Church Street and 20th Avenue North (Nashville, (Davidson County. The facility will be constructed in approximately 28,500 SF of rentable space in anew medical office building and

will contain nine (9) operating rooms and one (1) procedure room. The estimated project cost is **$29,836,377.00**. *Project Status: This project was recently approved.*

Surgery Center of Lebanon, CN1302-003A, has an outstanding Certificate of Need, which will expire on July 1, 2015. It was approved at the May 22, 2013 Agency meeting for the relocation of an approved but unimplemented Certificate of Need (CON) for a multi-specialty ambulatory surgical treatment center (ASTC) from its originally approved site at 101 Physicians Way, Lebanon Wilson County), TN to a new unaddressed site located on the east side of Blair Lane in Lebanon (Wilson County), TN. The surgery center will be a venture comprised of an LLC whose members are local physicians and Brentwood, Tennessee based Specialty Surgery Centers of America, Inc. Specialties to initially be offered include orthopedics, pain management, ENT (Ear, Nose, and Throat), general surgery and plastic surgery. The estimated project cost is **$2,212,467.** *Project Status: According to a December 9, 2013 email from a Surgery Center of Lebanon representative, the project is on schedule for a May, 2015 delivery. Architectural and engineering drawings are complete and have been approved by the City Planning Commission and await state submittal.*

Williamson County Hospital District d/b/a Williamson Medical Center, CN1210-048A, has an outstanding Certificate of Need which will expire on March 1, 2017. It was approved at the January 23, 2013 Agency meeting for the construction and renovation project that will renovate and expand surgery and surgery support areas on the east side of the main hospital building and construct a three-story addition on the west side of the main hospital building for pediatric services and shelled space for future relocation of obstetrics services. The estimated project cost is **$67,556,801.00.** *Project Status: A 10/01/2013 email from a representative of Williamson Medical Center indicated that the contractor had been chosen and that they were moving through the funding process this month. Groundbreaking is anticipated in late November, 2013.*

Saint Thomas Hospital, CN1110-037A, has an outstanding Certificate of Need which will expire on March 1, 2017. It was approved at the January 25, 2012 Agency meeting for construction of a three phase hospital construction project, including the renovation of 89,134 square feet of existing hospital space and the construction of a six level 135,537 sq. ft. patient tower to be adjoined to the hospital located at 4220 Harding Road, Nashville, TN. The services and areas affected include critical care, operating rooms, patient registration, patient admission and testing, surgery waiting, surgery pre/post-op, emergency department, chest pain clinic, cardiac short stay, PACU, cath lab holding and support space. Major medical equipment included in the project will include one additional GE Discovery CT750 HD 128-slice CT scanner. No additional services or licensed beds are being requested in the project. The estimated project cost is

$110,780,000. *Project Status update: According to a 10/2/13 email from a St. Thomas representative, Phase 1 of the project (renovations to the second floor of the hospital) is approximately 60% complete. Phase 2 work (new tower construction) is scheduled to begin mid-2014 and some Phase 3 work (reconfiguration of space that is not dependent on relocation of services to the new tower) is planned to start in the next several months. The overall project is expected to be complete in early 2017.*

Natchez Surgery Center, CN1002-011A, has an outstanding Certificate of Need which will expire on July 1, 2015. It was approved at the May 26, 2010 Agency meeting for the establishment of an ambulatory surgical treatment center (ASTC) with three (3) operating rooms and three (3) procedure rooms. After approval, CN801-001A was surrendered which is a similar facility for this site at 107 Natchez Park Drive, Dickson (Dickson County), TN. The estimated cost of the project was **$13,073,892.00.** *Project Status: The applicant requested a modification at the March 2012 Agency meeting to extend the expiration date for three (3) years from July 1, 2012 to July 1, 2015; reduce the number of operating rooms from three (3) to two (2) and procedure rooms from three (3) to one (1); reduce project costs by $4,201,823 from $13,073,892 to $8,872,069; and reduce square footage by 4,965 from 15,424 to 10,459 square feet. The Agency voted to defer consideration of this request until the May 2012 meeting so that it could be heard simultaneously with CN1202-008, Horizon Medical Center Emergency Department. Both CN1202-008 and the modification to CN1002-011A were approved at the May 2012 meeting. In a 6/27/13 Annual Progress Report, it was stated that the Natchez Surgery Center would be developed as a second stage of the freestanding emergency department (FSED) project. Initially the space for the ASTC will be shelled in during construction of the FSED. Then shortly after completion of the FSED, it is anticipated that the ASTC will be completed. It is anticipated that groundbreaking will take place by December 2013 and it is anticipated that the ASTC will be completed by July 1, 2015.*

Southern Sports Medicine Surgery Center, CN1204-019A, has an outstanding Certificate of Need which will expire on May 1, 2015. It was approved at the September 26, 2012 Agency meeting for the relocation of an approved, but unimplemented Certificate of Need for the establishment of an ambulatory surgical treatment center and expansion of the designated use of its previously approved single specialty ASTC (CN1104-013A) to include multi-specialty services. The proposed project will relocate from 1163 Nashville Pike, Gallatin (Sumner County), TN to 127 Saundersville Pike, Suite A, Hendersonville, (Sumner County), Tennessee. The estimated project cost was **$3,355,533.** *Project Status: This project was originally scheduled to expire on November 1, 2014. The project was subsequently appealed but then voluntarily dismissed May 8, 2013 extending the expiration date to May 1, 2015. An October 3, 2013 email from a representative of the applicant indicated that they have contracted with a national architectural firm and a local engineering firm, both of whom have been working diligently on their parts of the*

project. They have a letter of intent from a builder. Their site plan and building plan have been approved by the city of Hendersonville. Some of the preliminary site work has already been done. Plans either have been or will soon be sent to the Department of Health for approval.

Maury Regional Ambulatory Surgery Center, LLC, CN1111-046A, has an outstanding Certificate of Need which will expire on June 1, 2014. It was approved at the April 25, 2012 Agency meeting for the establishment of a multi-specialty ambulatory surgical treatment center (ASTC) on the second floor of a three story, 62,365 SF medical office building to be constructed on a 4.1 acre unaddressed site at the intersection of Saturn Parkway and Port Royal Road in Spring Hill (Maury County), Tennessee. The new 13,080 square foot facility will include two operating rooms (475 & 430 SF) and two procedure rooms (294 & 276 SF), 4 pre-op stations, 8 post-op stage-one stations and 4 post-op stage-two stations along with the requisite clinical, personnel, administrative and patient support areas. The estimated project cost was **$7,894,178.00.** *Project Status: According to a 10/2/13 email from a representative of Maury Regional, construction on the surgery center is 80% complete. The scheduled construction completion date was to be December 1, 2013.*

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

PME

(12/5/13)

LETTER OF INTENT

SEP 9 '13 AM 11:2

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Tennessean (Name of Newspaper) which is a newspaper of general circulation in Davidson (County), Tennessee, on or before September 13 (Month / day), 2013 (Year) for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency,

Vanderbilt University Hospitals (Name of Applicant) an existing acute care hospital (Facility Type-Existing)

owned by: Vanderbilt University with an ownership type of not-for-profit

and to be managed by: Vanderbilt University Hospitals intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]:

the expansion and renovation to the existing third floor operating suite by four operating rooms and by providing shell space for future expansion of two additional operating rooms at 1211 Medical Center Drive, Nashville, TN. Project costs include the four new operating rooms and associated equipment costs. The estimated project cost is $7,535,708.64. No major medical equipment will be involved. The total number of licensed beds will not change as a result of this project.

The anticipated date of filing the application is: September 13, 2013

The contact person for this project is Ronald W. Hill (Contact Name), Vice President, Business Development (Title)

who may be reached at: Vanderbilt University Medical Center (Company Name), 3319 West End Avenue, Suite 920 (Address)

Nashville (City), TN (State), 37203 (Zip Code), 615-936-6012 (Area Code / Phone Number)

Ronald W. Hill (Signature), 9/9/13 (Date), ron.hill@vanderbilt.edu (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
The Frost Building, Third Floor
161 Rosa L. Parks Boulevard
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

COPY-

Application Vanderbilt University Hospitals

CN1309-034

1. ***Name of Facility, Agency, or Institution***

Vanderbilt University Hospitals
Name

1211 Medical Center Drive — Davidson
Street or Route — County

Nashville — TN — 37232
City — State — Zip Code

2. ***Contact Person Available for Responses to Questions***

Ronald W. Hill — Vice President, Business Development
Name — Title

Vanderbilt University Medical Center — ron.hill@vanderbilt.edu
Company Name — Email address

3319 West End Ave. Suite 920 — Nashville — TN — 37203
Street or Route — City — State — Zip Code

Vice President in Parent Organization — 615-936-6012 — 615-936-5310
Association with Owner — Phone Number — Fax Number

3. ***Owner of the Facility, Agency or Institution: Attachment A.3***

Vanderbilt University Hospitals — 615-322-3454
Name — Phone Number

1211 Medical Center Drive — Davidson
Street or Route — County

Nashville — TN — 37232
City — State — Zip Code

4. ***Type of Ownership of Control (Check One): Attachment A.4***

A.	Sole Proprietorship		F.	Government (State of TN or Political Subdivision)	
B.	Partnership		G.	Joint Venture	
C.	Limited Partnership		H.	Limited Liability Company	
D.	Corporation(For Profit)		I.	Other (Specify)_____	
E.	Corporation (Not-for-Profit)	X			

5. ***Name of Management/Operating Entity (If Applicable)***

_____
Name

_____ _____
Street or Route County

_____ _____ _____
City State Zip Code

6. ***Legal Interest in the Site of the Institution (Check One): Attachment A.6***

A.	Ownership	X	D.	Option to Lease	
B.	Option to Purchase		E.	Other (Specify) _____	
C.	Lease of _____ Years				

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A.	Hospital (Specify) acute	X	I.	Nursing Home	
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty		J.	Outpatient Diagnostic Center	
C.	ASTC, Single Specialty		K.	Recuperation Center	
D.	Home Health Agency		L.	Rehabilitation Facility	
E.	Hospice		M.	Residential Hospice	
F.	Mental Health Hospital		N.	Non-Residential Methadone Facility	
G.	Mental Health Residential Treatment Facility		O.	Birthing Center	
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)		P.	Other Outpatient Facility (Specify)_____	
			Q.	Other (Specify) _____	

8. **Purpose of Review *(Check) as appropriate--more than one response may apply)***

A.	New Institution		H.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation]*	
B.	Replacement/Existing Facility				
C.	Modification/Existing Facility	X			
D.	Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify) Ambulatory Surgery		I.	Change of Location	
E.	Treatment Center Discontinuance of OB Services		J.	Other (Specify)_____	
F.	Acquisition of Equipment				
G.					

9. **Bed Complement Data** **Not Applicable; this project does not impact the bed complement.**
Please indicate current and proposed distribution and certification of facility beds.

		Current Licensed	*Beds *CON*	*Staffed Beds*	*Beds Proposed*	*TOTAL Beds at Completion*
A.	Medical					
B.	Surgical					
C.	Long-Term Care Hospital					
D.	Obstetrical					
E.	ICU/CCU					
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation					
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
	Swing Beds					
S.	Mental Health Residential Treatment					
T.	Residential Hospice					
U.	**TOTAL**					

10 **Medicare Provider Number** 440039: Acute Care
Certification Type Inpatient facility

11. **Medicaid Provider Number** 440039: Acute Care
Certification Type Inpatient facility

12. **If this is a new facility, will certification be sought for Medicare and/or Medicaid?**

Not Applicable

13. ***Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.*** **Will this project involve the treatment of TennCare participants? YES If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted *or plans to contract.***

See Attachment A.13 for existing MCO contracts.

SECTION B: PROJECT DESCRIPTION

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

The proposed project is to add four operating rooms to the existing third floor surgery suites of Vanderbilt University Hospital. Two additional rooms will be developed as shell space to accommodate the potential for future surgical patient volume growth. The expansion is on the third floor of the existing adult hospital and the area of renovation is immediately adjacent to the exiting surgical suites. No major medical equipment will be involved.

Vanderbilt University, by and through its Vanderbilt University Medical Center, owns the Vanderbilt University Hospital facilities. The project will utilize 9,108 square feet of renovated space currently used as a support area.

The planned increase in number of operating rooms is a consequence of high current surgical volume and projections for future growth as patients continue to access the subspecialty surgical care available at Vanderbilt. Patients from an extended service area, including patients from out of state, utilize the facility.

The expected project cost is $7,535,708.64. Funding will be through reserves available to Vanderbilt. The project is expected to show positive cash flow within the first full year of operation given projected volumes.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal

A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

The proposed project is for construction of four additional operating rooms on the third floor of Vanderbilt University Hospital. In addition to the new operating rooms, the proposal includes shelled construction for two additional operating rooms that will be utilized for future demand. The addition of the operating rooms is needed due to the substantial growth of surgical patient volume at Vanderbilt.

The four operating rooms range between 595 square feet and 616 square feet with the future shell space measuring 2,739 square feet. In addition to the operating rooms, a clean corridor (1,189 square feet) and support space (902 square feet) are included in the project. The total project is 9,108 square feet, which includes 751 square feet of mechanical space and 1,092 square feet of circulation space. Total construction costs will be $4,326,482 or $475.02 per square foot. These costs are believed to be reasonable due to the extensive mechanical and electrical work demanded by this project.

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

Not Applicable

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
OR # 1	n/a	n/a	n/a		614	n/a	614			
OR # 2	n/a	n/a	n/a		616	n/a	616			
OR # 3	n/a	n/a	n/a		595	n/a	595			
OR # 4	n/a	n/a	n/a		610	n/a	610			
Clean Core	n/a	n/a	n/a		1189	n/a	1189			
Shell Space	n/a	n/a	n/a		2739	n/a	2739			
Support Space	n/a	n/a	n/a		902	n/a	902			
B. Unit/Depart. GSF Sub-Total					7265	n/a	7265			
C. Mechanical/ Electrical GSF					751		751			
D. Circulation/ Structure GSF					1092		1092			
E. Total GSF					9108		9108	$475.02	n/a	$475.02

C. As the applicant, describe your need to provide the following health care services (if applicable to this application): **Not Applicable**

1. Adult Psychiatric Services
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. Home Health Services
9. Hospice Services
10. Residential Hospice
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20. Rehabilitation Services
21. Swing Beds

D. Describe the need to change location or replace an existing facility. **Not Applicable**

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $2.0 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed-site major medical equipment: **Not Applicable**

    a. Describe the new equipment, including:

        1. Total cost; (As defined by Agency Rule).
        2. Expected useful life;
        3. List of clinical applications to be provided; and

    b. Documentation of FDA approval.

    c. Provide current and proposed schedules of operations

2. For mobile major medical equipment: **Not Applicable**

    a. List all sites that will be served;

    b. Provide current and/or proposed schedule of operations;

    c. Provide the lease or contract cost;

d. Provide the fair market value of the equipment; and

e. List the owner for the equipment.

3. Indicate applicant's legal interest in equipment (*i.e.*, purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Not Applicable

III. **(A)** Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which **must include:**

1. Size of site (***in acres***); **Proposed site consists of 4.1 acres**
2. Location of structure on the site; and
3. Location of the proposed construction;
4. Names of streets, roads or highway that cross or border the site.

Please see Attachment B.Project Description.III.A – Plot Plan

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Vanderbilt is accessible from most major transportation routes including Highways I-65, I-440, and I-40. Public transportation access includes bus stops near the hospital on 21st Avenue South.

IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.

Please see Attachment B.Project Description.IV – Floor Plan

V. For a Home Health Agency or Hospice, identify: **N.A.**

1. Existing service area by County;
2. Proposed service area by County;
3. A parent or primary service provider;
4. Existing branches; and
5. Proposed branches.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care.

NEED

1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.

   a. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project.

      Not Applicable

   b. Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c)

      Not Applicable

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

   The proposed project is a consequence of high current surgical volume and projections for future growth as patients continue to access the subspecialty surgical care available at Vanderbilt. Patients from an extended service area, including patients from out of state, utilize the facility. There were roughly 30,645 adult surgical cases at VUH in FY13. In addition, the Vanderbilt surgical case volume currently at the Nashville Surgery Center will be relocated to VUH in October 2014, resulting in approximately 3,000 additional cases. As a result of this relocation and the demand for surgical services, it is projected that there will be approximately 38,600 surgical cases by FY17 at VUH.

   In order to meet these volume projections, the additional operating rooms are necessary.

   Vanderbilt's plans are also similar to the Five Principals for Achieving Better Heath as articulated in the 2009 State Health Plan.

   1. **Healthy Lives: The proposed project will improve the health of the service area through the improved efficiencies gained by expanding the operating rooms in the current location. The health care system is moving to a recognition that population based approaches to care will be the prevailing approach for assuring healthy lives in the future.**

   2. **Access to Care: The proposed project will improve access to care by allowing Vanderbilt to expand capacity of the subspecialty surgical care available. Recent Blue Cross Blue Shield of Tennessee white paper evidences the in-migration to major referral centers from the outlying areas. In Vanderbilt's case, much of this in-migration is no doubt a product of the complete array of surgical subspecialties available.**

   3. **Economic Efficiencies: The proposed project will achieve operational efficiencies by expanding the operating room capacity adjacent to the existing operating rooms at VUH.**

This expansion will also improve patient flow and care coordination by utilizing existing resources. Vanderbilt is committed to an evidenced-based approach to the delivery of care, which will also assure cost-effective approaches to patient care.

4. **Quality of Care: The proposed project will achieve the highest standards of quality through quality metrics and best practices in conjunction with the other operating rooms at VUH. Vanderbilt is actively engaged in many projects associated with quality and safety outcomes and is recognized as a national leader in this regard.**

5. **Health Care Workforce: Vanderbilt is committed to providing world-class care at the medical center, and thus, recruiting and retaining the best employee workforce. This will be an increasing challenge in the healthcare environment in the future as resources and reimbursement become more constrained.**

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. **Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

The area to be served by this proposal is represented in the attached Service Area map (Attachment C.Need.3). The primary service area includes the counties of Davidson, the remaining counties of Nashville MSA, Central TN, and specific counties in Western KY. This area is reasonable as 82% of VUMC's surgical patients derive from this area.

4. A. Describe the demographics of the population to be served by this proposal.

Please see Attachment C.Need.4.A.

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Fifty-four percent of Vanderbilt University Medical Center's surgical patients were TennCare/ Medicaid, Medicare, and uninsured inpatients, which is evidence of the commitment to low-income and elderly consumers. VUMC provides services to all consumers irrespective of gender, race, ethnicity or income. Many programs, such as multi-language translation capabilities are implemented to assure ease of access. Several programs in conjunction with Meharry Medical Center specifically research and address disparities in health outcomes associated with the minority populations.

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

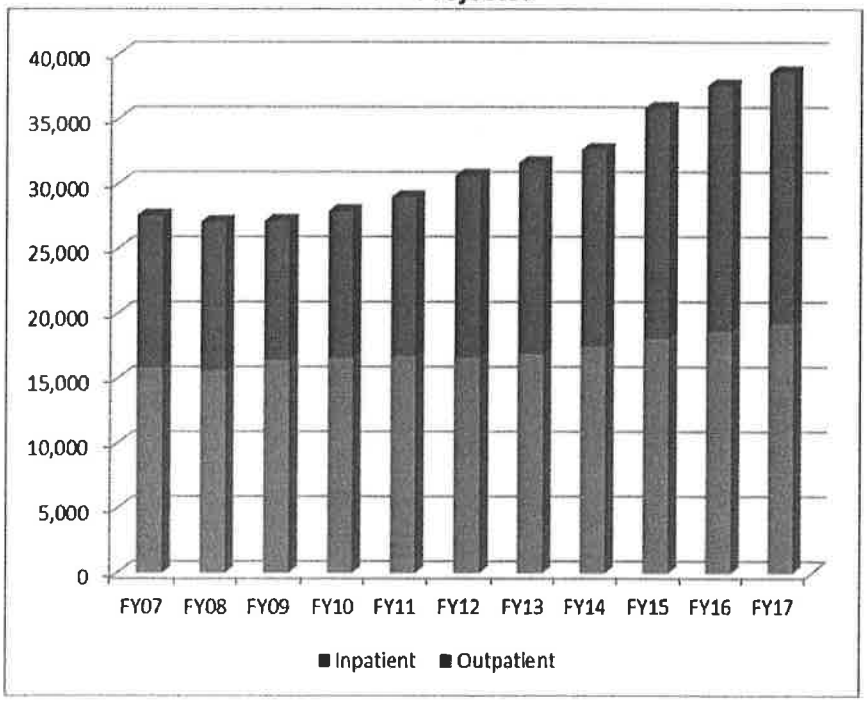
The proposed project is for the addition of operating rooms in VUH; there are no new services proposed in this project. Please see Attachment C.Need.5. Within the proposed Middle Tennessee service area, there

are 39 hospitals that provide surgical services. Of these hospitals, Vanderbilt is the leading surgical provider, performing more than twice the number of surgical cases than any other provider in the Middle Tennessee market. This is a result of patients choosing VUH for the high quality, subspecialty care available at the hospital.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

Vanderbilt surgical volumes over the last three years continue to experience substantial growth. This is evidenced by growth rates ranging between 3% for inpatient cases and 12% for outpatient cases over the last several years. However, for the project, a more conservative growth rate of 3% is used for the subsequent fiscal years represented in the chart below. In addition, please note that the Nashville Surgery Center cases are projected to be absorbed in FY15.

Vanderbilt University Hospital
Operating Rooms
Historical and Projected Growth



ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

The project costs are believed to be reasonable due to the extensive mechanical and electrical work demanded by this project.

- For projects that include new construction, modification, and/or renovation; **documentation must be** provided from a contractor and/or architect that support the estimated construction costs.

  See Attachment C. Economic Feasibility.1

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:		
	1.	Architectural and Engineering Fees	$ 346,482
	2.	Legal, Administrative, Consultant Fees	$ 5,000
	3.	Acquisition of Site	$ -
	4.	Preparation of Site	$ -
	5.	Construction Costs	$ 4,326,482
	6.	Contingency Fund	$ 20,000
	7.	Fixed Equipment	$ 1,601,400
	8.	Moveable Equipment (List all equipment over $50,000) Anesthesia Machine (4) Table, Surgical Bariatric (4)	$ 1,219,427.36
	9.	Other (Specify) _____	$
B.	Acquisition by gift, donation, or lease: **N/A**		
	1.	Facility	$ -
	2.	Building only	$ -
	3.	Land only	$ -
	4.	Equipment (Specify)_____	$ -
	5.	Other (Specify) _____	$ -
C.	Financing Costs and Fees: **N/A**		
	1.	Interim Financing	$ -
	2.	Underwriting Costs	$ -
	3.	Reserve for One Year's Debt Service	$ -
	4.	Other (Specify) _____	$ -
D.	Estimated Project Cost (A+B+C)		$ 7,518,791.36
E.	CON Filing Fee		$ 16,917.28
F.	Total Estimated Project Cost (D+E)		
		TOTAL	**$ 7,535,708.64**

2. Identify the funding sources for this project.

Please check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

__ A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

__ B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

__ C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.

__ D. Grants--Notification of intent form for grant application or notice of grant award; or

X E. Cash Reserves--Appropriate documentation from Chief Financial Officer.

__ F. Other—Identify and document funding from all other sources.

See Attachment C.Economic Feasibility.2.E (Proof of Cash Reserves)

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

VUMC costs for this project are slightly higher when compared to the other recently approved Tennessee CON projects due to the higher construction costs involved with surgical facilities and the mechanical requirements. The chart provided below shows the average hospital construction cost per square foot for all CON-approved applications during 2012; source is Tennessee HSDA.

Hospital Construction Cost per Square Foot
Approved Projects, 2010-2012

	Renovated Construction	New Construction	Total Construction
1st Quartile	$99.12/sq ft	$234.64/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$259.66/sq ft	$235.00/sq ft
3rd Quartile	$249.00/sq ft	$307.80/sq ft	$274.63/sq ft

Complete Historical and Projected Data Charts on the following two pages--***Do not modify the Charts provided or submit Chart substitutions!*** Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart

should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

4. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

Average Gross Charge	**$ 40,294**
Average Deduction from Operating Revenue	**$ 29,286**
Average Net Charge	**$ 11,008**

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month).

		FY10	FY11	FY12
A.	Utilization Data	81.6%	82.3%	81.2%
B.	Revenue from Services to Patients			
1.	Inpatient Services	$2,565,513,684	$2,958,557,574	$2,946,427,273
2.	Outpatient Services	$1,799,223,854	$1,996,237,552	$2,284,864,589
3.	Emergency Services	$158,393,280	$172,746,469	$222,701,528
4.	Other Operating Revenue	$11,626,896	$13,817,470	$11,755,661
	Gross Operating Revenue	$4,534,757,714	$5,141,359,065	$5,465,749,051
C.				
1.	Contractual Adjustments	$2,564,607,441	$2,999,262,282	$3,157,381,889
2.	Provision for Charity Care	$232,539,044	$278,807,927	$312,846,669
3.	Provisions for Bad Debt	$83,089,700	$92,620,466	$90,645,441
	Total Deductions	$2,880,236,185	$3,370,690,675	$3,560,873,999
NET OPERATING REVENUE		$1,654,521,529	$1,770,668,390	$1,904,875,052
D.	Operating Expenses			
1.	Salaries and Wages	$466,408,164	$489,548,937	$535,813,562
2.	Physician's Salaries and Wages	$74,450,987	$83,324,502	$95,493,800
3.	Supplies	$313,172,848	$329,166,755	$362,423,688
4.	Taxes	$307,807	$488,370	$553,109
5.	Depreciation	$62,300,576	$67,575,449	$67,543,321
6.	Rent	$13,958,059	$18,375,582	$18,112,703
7.	Interest, other than Capital			
8.	Other Expenses	$581,969,611	$624,633,138	$649,491,163
	Total Operating Expenses	$1,512,568,052	$1,613,112,733	$1,729,431,346
E.	Other Revenue (Expenses) – Net	$1,407,347	$2,105,590	$1,201,758
NET OPERATING INCOME (LOSS)		$143,360,824	$159,661,247	$176,645,464
F.	Capital Expenditures			
1.	Retirement of Principal	$11,455,000	$12,385,000	$21,716,763
2.	Interest	$40,623,428	$44,481,069	$50,747,353
	Total Capital Expenditures	$52,078,428	$56,866,069	$72,464,116
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$91,282,396	$102,795,178	$104,181,348

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in ___July___ (Month).

		FY16	FY17
A.	Utilization Data (cases)	2,675	2,729
B.	Revenue from Services to Patients		
1.	Inpatient Services	$72,695,280	$74,162,774
2.	Outpatient Services	$35,092,393	$35,800,800
3.	Emergency Services		
4.	Other Operating Revenue (Specify)_____		
	Gross Operating Revenue	$107,787,673	$109,963,574
C.	Deductions for Operating Revenue		
1.	Contractual Adjustments	$69,464,626	$70,866,903
2.	Provision for Charity Care	$6,882,847	$7,021,791
3.	Provisions for Bad Debt	$1,994,264	$2,034,522
	Total Deductions	$78,341,737	$79,923,215
NET OPERATING REVENUE		$29,445,936	$30,040,359
D.	Operating Expenses		
1.	Salaries and Wages	$5,329,333	$5,436,916
2.	Physician'sSalaries and Wages		
3.	Supplies (Medical Supplies & Services)	$6,996,465	$7,137,702
4.	Taxes		
5.	Depreciation	$550,000	$550,000
6.	Rent		
7.	Interest, other than Capital		
8.	Other Expenses (Specify) Non-salary, non-supply direct costs and indirect costs	$13,358,794	$13,628,467
	Total Operating Expenses	$26,234,593	$26,753,085
E.	Other Revenue (Expenses) -- Net (Specify)		
NET OPERATING INCOME (LOSS)		$ 3,211,343	$3,287,273
F.	Capital Expenditures		
1.	Retirement of Principal		
2.	Interest		
	Total Capital Expenditures		
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$ 3,211,343	$3,287,273

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6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Average charges for the procedures can be derived from historic utilization experience and this method was used to obtain the anticipated charges and revenue for the proposed project provided in the Projected Data Chart. The average gross charge for procedures being performed in the proposed project is $40,294 while the average net revenue per case is $11,008. There should be no adjustments to current charges based on implementation of this project. See Attachment C.Economic Feasibility.6.A (List of Procedures).

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

The Medicare allowable payment rate for the top CPT codes that will be performed is provided below.

		Medicare Allowable Payment Rate
47563	LAPAROSCOPIC CHOLECYSTECTOMY W/WO IOC	$3,487.15
49505	INGUINAL HERNIORRAPHY W/WO MESH	$2,429.11
50081	PERCUTANEOUS NEPHROLITHOTOMY	$3,261.04
52235	TRANSURETHRAL RESECTION BLADDER TUMOR (TURBT)	$1,908.86
52332	CYSTOSCOPY; URETERAL STENTS	$1,908.86
52353	URETEROSCOPY W/WO LITHOTRIPSY	$2,737.09

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

The proposed project will improve operational efficiency on the main VUH campus. As indicated in the Projected Data Chart, projected utilization will allow VUMC to maintain cost-effectiveness.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved

The proposed utilization rate provides a positive cash flow in Year 1.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

In FY10-11 and FY11-12, 45% of Vanderbilt's revenue was Medicare, Medicaid, Bad Debt and Charity Care. In addition, the payer mix of the proposed project represents the payer mix of current surgical patients at Vanderbilt.

	FY2010-2011		FY2011-2012		FY2015-2016		FY2016-2017	
	Revenue	% of Total	Revenue	% of Total	Revenue	% of Total	Revenue	% of Total
Medicare	$ 988,129,937	19%	$ 1,094,974,255	20%	$ 43,115,069	40%	$ 43,985,430	40%
Medicaid	$ 959,287,641	19%	$ 993,426,703	18%	$ 7,545,137	7%	$ 7,697,450	7%
Bad Debt	$ 92,620,466	2%	$ 90,645,441	2%	$ 2,155,753	2%	$ 2,199,271	2%
Charity Care	$ 278,807,927	5%	$ 312,846,669	6%	$ 5,389,384	5%	$ 5,498,179	5%
Subtotal	$ 2,318,845,971	45%	$ 2,491,893,068	46%	$ 58,205,343	54%	$ 59,380,330	54%
Other	$ 2,808,695,624	55%	$ 2,962,100,322	54%	$ 49,582,330	46%	$ 50,583,244	46%
Total Gross Revenue	$ 5,127,541,595	100%	$ 5,453,993,390	100%	$ 107,787,673	100%	$ 109,963,574	100%

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility.10.

See Attachment C, Economic Feasibility.10.

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

    a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

    b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

    In order to maintain operational effectiveness and efficiencies, there was not an alternative to the proposed project, which is adjacent to all the major resources committed to surgical care at VUH.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

   Please see Attachment C. Contribution to the Orderly Development of Healthcare.1

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

   The proposed project will improve access to care by allowing Vanderbilt to expand capacity of the subspecialty surgical care available. Recent Blue Cross Blue Shield of Tennessee white paper evidences the in-migration to major referral centers from the outlying areas. In Vanderbilt's case, much of this in-migration is no doubt a product of the complete array of surgical subspecialties available.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff

salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

Proposed Staffing Pattern:

RN 9.4
ST 5.6
RNFA 2

The salaries proposed for the clinical staff positions will equal or exceed the rates provided in the TN Department of Labor & Workforce Development Occupational Employment Statistics Survey.

Clinical Staff Position	VUMC	Mean	25th Percentile	Median	75th Percentile
Registered Nurse	$ 26.75	$ 31.00	$ 23.65	$ 28.90	$ 34.75
Surgical Technologist	$ 18.63	$ 19.85	$ 16.20	$ 18.60	$ 23.25
RN Facility Administrator	$ 47.48	$ 45.15	$ 30.95	$ 39.40	$ 53.75

**Hourly Rate*

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

Vanderbilt University Medical Center will staff the facility. Vanderbilt University Medical Center and Vanderbilt University are uniquely partnered to provide a dynamic recruitment and retention program for employees. As the largest Nashville employer, other than the State of Tennessee, we actively search for the most appropriate candidates and seek to place them in career successful positions. Recruitment of technical and professional staff for the project is not expected to be a problem given the desirable employment environment and benefit structure at Vanderbilt.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education

Vanderbilt University Medical Center will be responsible for credentialing, quality assurance, and staff education.

Credentialing

The Provider Support Services department credentials all providers that will admit patients to VUMC or attend to patients at VUMC and its satellite locations. Documents are verified from the primary source and include medical or professional licenses, DEA status (if applicable), malpractice insurance and claims history, appropriate schooling, board certification and faculty status. Once all documents have been verified, they are presented to the Credentials Committee for review and recommendation to the Medical Center Medical Board. The Medical Center Medical Board then recommends approval to the Board of Trust, which makes the final decision.

Quality Assurance

VUMC's Performance Improvement and Safety Plan is framed around the Institute of Medicine's (IOM) Quality Chasm Report. It incorporates the IOM Six Aims for Improvement (i.e. care that is safe, timely, efficient, effective, equitable, and patient-centered). The fundamental integrity of the Plan is based on the pivotal roles played by the VU Board of Trust, the Medical Center Medical Board, and the VUMC Quality Council (which is chaired by the Associate Vice Chancellor) in ensuring an effective, hospital-wide effort.

The Performance Improvement Plan incorporates the traditional quality control/quality assurance monitors as well as leadership-defined, performance improvement initiatives tied to the institution's Strategic Plan. Significant resources are devoted to implementing the plan through the Center for Clinical Improvement and the Accreditation and Standards Departments. The plan is reviewed and revised annually based upon senior leadership's assessment of effectiveness.

In addition, each year an Employee Performance Competency Report is issued to the Board of Trust, which is reviewed in accordance with administrative policy and JCAHO standards. This report includes competency maintenance activities that are required on a yearly basis for all employees. For those that are not up to the required standards, performance improvement efforts are implemented with customized plans to meet individual staff needs. Those that do not meet the objectives of the improvement plan are terminated for cause.

Staff Education

VUMC devotes a variety of resources to the development of staff at all levels of the organization. VUMC's Learning Center provides comprehensive orientation and role specific training to help new staff become successful in their jobs. In partnership with Environmental Health Services, Offices for Compliance and Accreditation, the Learning Center assists all staff in meeting competencies and regulatory requirements. Other programs enable individual staff to develop collaborative teamwork skills, manage conflict, improve communication, precept other staff or fulfill roles of responsibility within their work groups.

Radiology, Nursing, Pharmacy, Nutrition Services, and Rehabilitation Services Departments are leaders in providing continuing education for their staff. Programs are offered centrally and in unit and discipline-specific forums. Managers and administrators are supported in developing financial skills by VUMC's Department of Finance, which has its own training division. In addition, nursing managers are supported through a development program in conjunction with the Health Care Advisory Board and the Learning Center.

As employees of Vanderbilt University, VUMC staff has access to a variety of training classes offered by Human Resource Services. The classes are divided into four series, grouped by the type of skills that are emphasized: Leadership, Business/Interpersonal, Administrative, and Individual Growth and Development. HRS also provides customized training and facilitation classes for individual teams.

The Department of Systems Support provides the technical training to implement the many state-of-the-art patient information systems used in daily patient care. Finally, many tools and resources are available on-line at the Learning Center, Department of Finance and Human Resources websites.

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.,* internships, residencies, etc.).

VUMC has accredited training programs in medicine, radiation oncology (residents), medical physicists and dosimetrists, nursing, pharmacy, respiratory therapy, dietetics, medical technology, radiation therapy technology, cardiovascular perfusion technology and nuclear medicine technology. VUMC is also a major clinical training facility for Vanderbilt University Medical and Nursing Schools. VUMC supports a total house staff training program of 697 residents and 279 fellows.

7. (a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.

The proposed facility will be constructed and operated to comply with all existing codes and license requirements.

(b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure: State of Tennessee, Department of Health Facilities, Licensure Division

(c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

Please see Attachment C. Contribution to the Orderly Development of Healthcare.7.c

(d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

Please see Attachment C. Contribution to the Orderly Development of Healthcare.7.d

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

Not Applicable

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project

Not Applicable

10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.

If this proposal is approved, Vanderbilt University Hospital will provide the Tennessee Health Services and Development Agency with information concerning the number of patients treated, the number and type of procedures performed and other requested data.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in Rule 68-11-1609(c): December, 2013
Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed	30	January 2014
2. Construction documents approved by the Tennessee Department of Health	30	January 2014
3. Construction contract signed	30	January 2014
4. Building permit secured	30	January 2014
5. Building construction commenced	62	March 2014
6. Construction 40% complete	126	May 2014
7. Construction 80% complete	190	July 2014
8. Construction 100% complete-approved for occupancy	222	September 2014
9. *Issuance of license	252	November 2014
10. *Initiation of service	252	November 2014
11. Final Architectural Certification of Payment	282	December 2014
12. Final Project Report Form (HF0055)	282	December 2014

***For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

Form HF0004
Revised 05/03/04
Previous Forms are obsolete

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Davidson

SEP 13 '13 AM11:3E

Ronald W. Hill, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

Ronald W. Hill

Vice President, Business Development

Sworn to and subscribed before me this 12th day of September (Month), 2013 (Year), a Notary Public in and for the County/State of Davidson County, Tennessee.

Jennifer Hygrell

NOTARY PUBLIC

My commission expires May 5 (Month/Day), 2015 (Year).

JENNIFER HYGRELL
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON

Vanderbilt University Medical Center OR Renovation CON Application Attachments
(in order of appearance)

Corporate Charter & Cert of Existence: Attachment A.3

Org Chart and Ownership List: Attachment A.4

Title/Deed: Attachment A.6

VUH MCO Contracts and Networks: Attachment A.13

Plot Plan: Attachment B.Project Description.III.A

Floor Plan: Attachment B.Project Description.IV

Service Area Map: Attachment C.Need.3

Primary Service Area Demographic Chart: Attachment C.Need.4.A

Surgical Services: Attachment C.Need.5

Estimated Construction Cost Letter: Attachment C.Economic Feasibility.1

Funding Documentation (proof of cash reserves): Attachment C.Economic Feasibility.2.E

List of Procedures: Attachment C.Economic Feasibility.6.A

VUMC Financial Statements: Attachment C.Economic Feasibility.10

Contracts: Attachment C.Contribution to the Orderly Development of Healthcare.1

Licensure & Accreditation: Attachment C.Contribution to the Orderly Development of Healthcare.7.c

Licensure Certification & Plan of Correction: Attachment C.Contribution to the Orderly Development of Healthcare.7.d

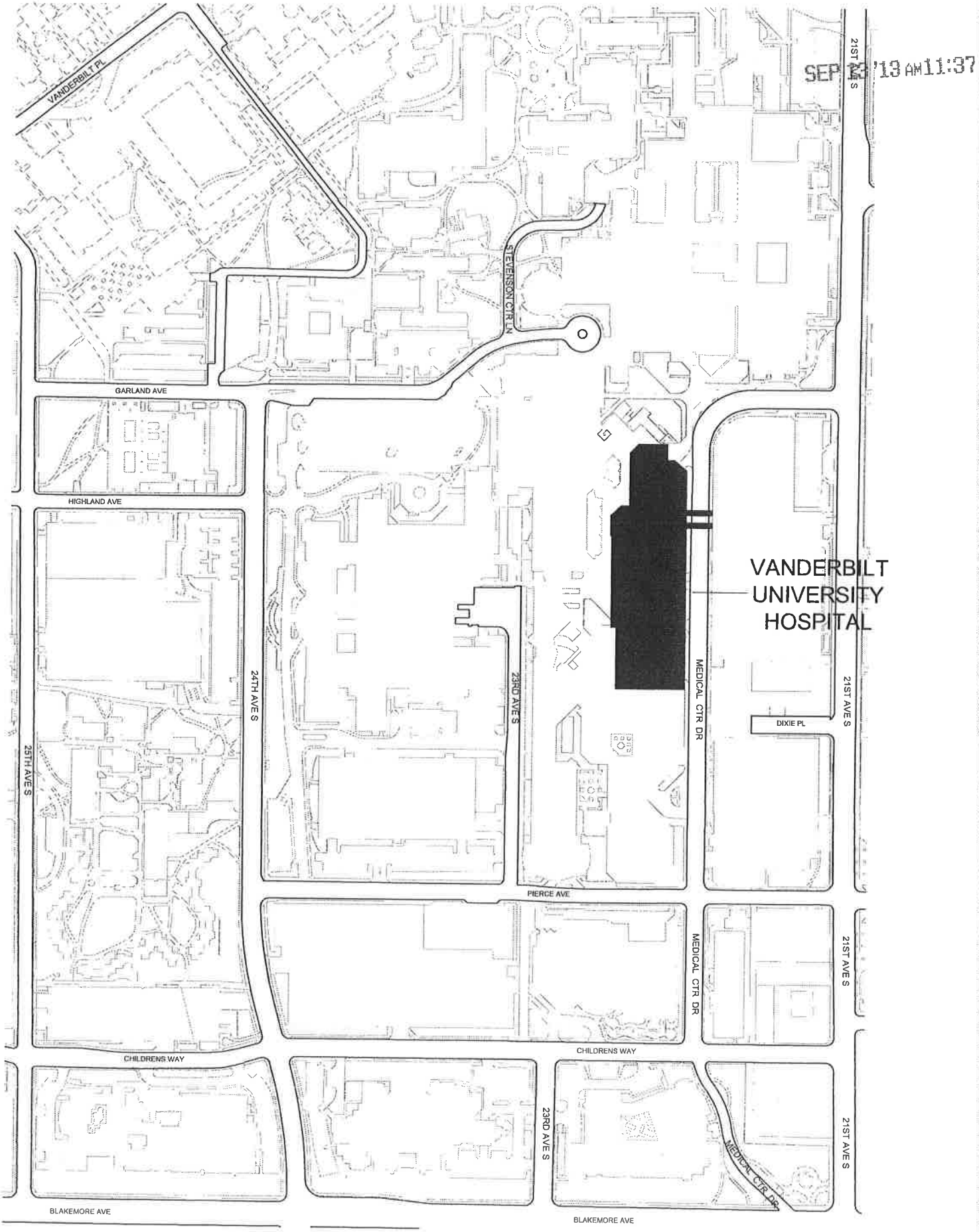
Proof of publication

Attachment B.Project Description.III.A

Plot Plan

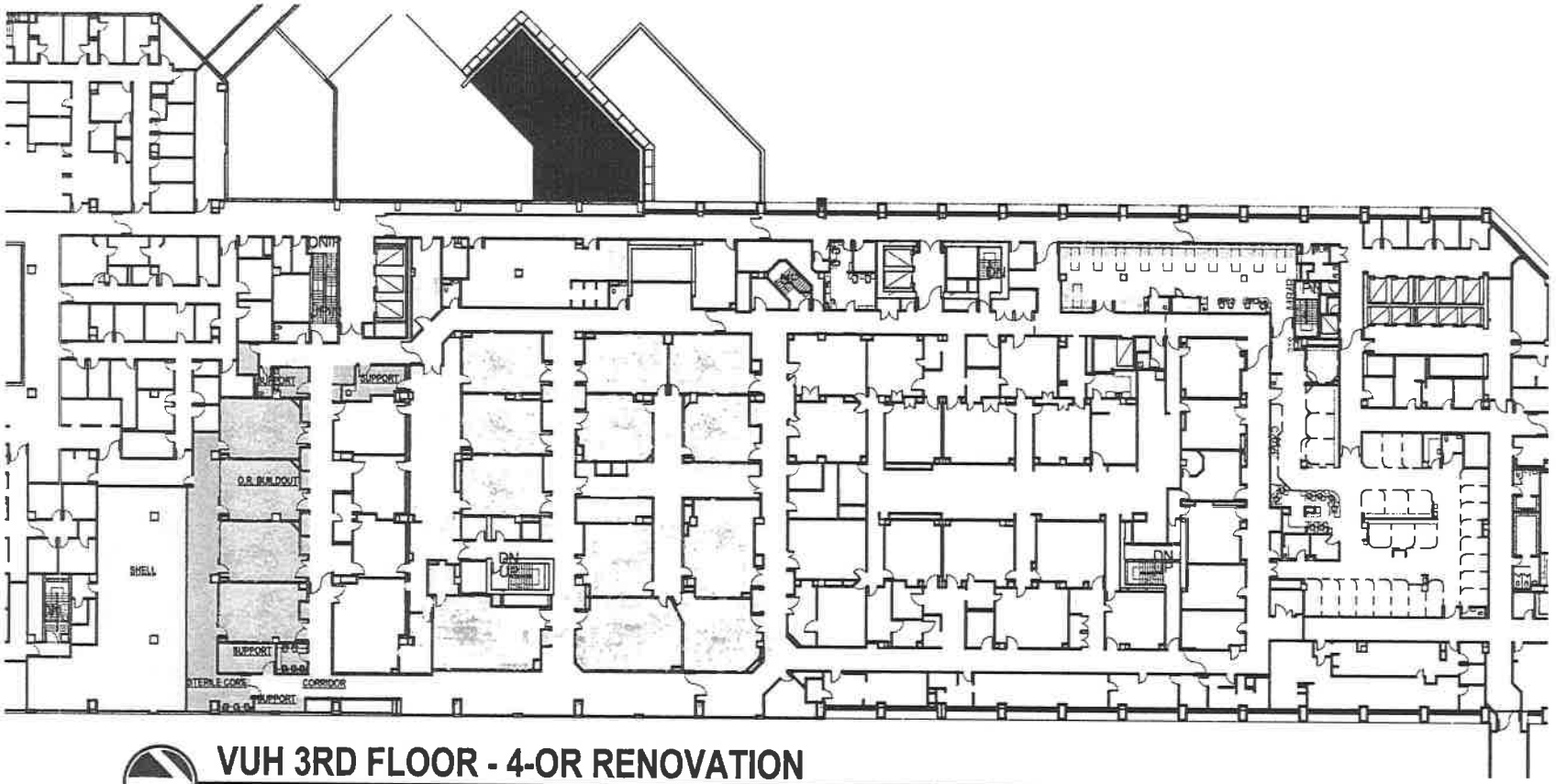

330 Acres
VANDERBILT UNIVERSITY
Campus Planning & Construction
Facilities Information Services
Aerial Photo Date:
January 2011
0
300
600
Feet

VANDERBILT UNIVERSITY MEDICAL CENTER



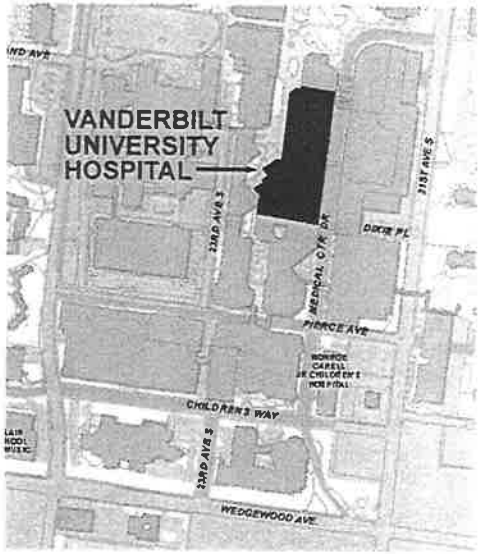
Attachment B.Project Description.IV

Floor Plan



VUH 3RD FLOOR - 4-OR RENOVATION

0 20' 40' 80'



KEY PLAN

Attachment C.Need.3

Service Area Map

Service Area

Attachment C.Need.5

Surgical Services

2009 Joint Annual Report of Hospitals
Schedule D - Page 12

			Surgery							
			Inpatient				Outpatient			
ID	Hospital	County	Service Provided	Encounters	# O.R.'s	Procedures	Service Provided	Encounters	# Dedicated O.R.'s	Procedures
02214	Heritage Medical Center	Bedford	Yes	367	3	734	Yes	1,550	1	2,066
08214	Stones River Hospital	Cannon	Yes	151	2	12	Yes	595	0	1,176
11204	Centennial Medical Center at Ashland City	Cheatham	No	0	0	0	Yes	175	1	175
14204	Cumberland River Hospital	Clay	Yes	15	0	15	Yes	153	1	168
16214	United Regional Medical Center	Coffee	Yes	0	2	141	Yes	0	3	719
16234	Harton Regional Medical Center	Coffee	Yes	1,962	5	2,118	Yes	4,050	2	5,035
16244	Medical Center of Manchester	Coffee	Yes	- 257	2	264	Yes	720	2	764
18224	Cumberland Medical Center, Inc.	Cumberland	Yes	1,683	9	3,096	No	2,909	0	4,867
19214	Southern Hills Medical Center	Davidson	Yes	1,148	10	1,408	Yes	2,662	10	4,318
19234	Skyline Medical Center Campus	Davidson	No	0	0	0	No	0	0	0
19244	Metropolitan Nashville General Hospital	Davidson	Yes	1,295	9	1,295	Yes	1,780	0	1,780
19254	Baptist Hospital	Davidson	Yes	9,008	26	24,852	Yes	8,054	0	14,023
19274	Saint Thomas Hospital	Davidson	Yes	7,857	18	24,554	Yes	2,885	2	5,360
19284	Vanderbilt University Hospitals	Davidson	Yes	21,283	54	40,462	Yes	18,597	3	30,627
19324	Centennial Medical Center	Davidson	Yes	8,690	33	12,733	Yes	11,571	4	17,845
19334	Skyline Medical Center	Davidson	Yes	2,393	12	0	Yes	3,081	0	0
19344	Summit Medical Center	Davidson	Yes	1,962	10	2,138	Yes	3,797	0	4,299
19354	The Center for Spinal Surgery	Davidson	Yes	1,158	6	1,158	No	2,102	0	2,102
19404	Middle Tennessee Mental Health Institute	Davidson	No	0	0	0	No	0	0	0
19754	Kindred Hospital - Nashville	Davidson	No	0	0	0	No	0	0	0
19764	Vanderbilt Stallworth Rehabilitation Hospital	Davidson	No	0	0	0	No	0	0	0
19784	Select Specialty Hospital - Nashville	Davidson	No	0	0	0	No	0	0	0
21234	DeKalb Community Hospital	Dekalb	Yes	205	3	378	Yes	1,620	0	3,496
22204	Horizon Medical Center	Dickson	Yes	1,365	7	2,730	Yes	3,698	0	5,177
25204	Jamestown Regional Medical Center	Fentress	Yes	0	2	426	Yes	0	1	420
26204	Emerald - Hodgson Hospital	Franklin	No	0	0	0	No	0	0	0
26224	Southern Tennessee Medical Center	Franklin	Yes	0	6	976	Yes	0	0	2,298
28214	Hillside Hospital	Giles	Yes	448	4	0	Yes	1,521	0	0
41214	Hickman Community Hospital	Hickman	No	0	0	0	No	0	0	0
42204	Patient's Choice Medical Center of Erin, TN	Houston	Yes	0	3	0	Yes	28	0	28
43204	Three Rivers Hospital	Humphreys	Yes	1	2	2	Yes	48	0	57
50234	Crockett Hospital	Lawrence	Yes	678	6	678	Yes	2,102	0	2,102
52214	Lincoln Medical Center	Lincoln	Yes	210	2	210	Yes	895	1	895
56204	Macon County General Hospital	Macon	Yes	0	1	0	Yes	218	1	253
59244	Marshall Medical Center	Marshall	Yes	45	2	53	Yes	487	0	541
60224	Maury Regional Hospital	Maury	Yes	3,057	11	6,319	Yes	4,345	2	7,371

Source: Tennessee Department of Health, Division of Health Statistics

2009 Joint Annual Report of Hospitals Schedule D - Page 12			Surgery							
			Inpatient				Outpatient			
ID	Hospital	County	Service Provided	Encounters	# O.R.'s	Procedures	Service Provided	Encounters	# Dedicated O.R.'s	Procedures
63204	Gateway Medical Center	Montgomery	Yes	2,111	10	2,418	Yes	4,095	0	4,650
67214	Livingston Regional Hospital	Overton	Yes	572	3	572	Yes	1,676	4	1,676
68204	Perry Community Hospital	Perry	Yes	4	0	4	Yes	100	1	100
71204	Cookeville Regional Medical Center	Putnam	Yes	2,528	10	3,559	Yes	6,249	0	8,480
74214	NorthCrest Medical Center	Robertson	Yes	1,160	5	1,217	Yes	3,478	0	3,650
75214	Middle Tennessee Medical Center, Inc.	Rutherford	Yes	0	10	3,285	Yes	0	0	4,431
75234	StoneCrest Medical Center	Rutherford	Yes	1,861	7	1,861	Yes	4,467	0	4,467
80204	Riverview Regional Medical Center North	Smith	Yes	0	2	367	Yes	0	1	1,114
80214	Riverview Regional Medical Center South	Smith	No	0	0	0	No	0	0	0
83204	Portland Medical Center	Sumner	No	0	0	0	No	0	0	0
83244	Sumner Regional Medical Center	Sumner	Yes	1,562	6	0	Yes	3,306	2	0
83254	Hendersonville Medical Center	Sumner	Yes	1,769	8	9,123	Yes	6,128	0	15,083
85214	Trousdale Medical Center	Trousdale	Yes	38	1	138	Yes	154	1	167
89234	River Park Hospital	Warren	Yes	690	4	786	Yes	1,922	2	2,009
91214	Wayne Medical Center	Wayne	Yes	18	1	18	No	0	0	0
93204	White County Community Hospital	White	Yes	240	2	240	Yes	1,085	1	1,085
94234	Williamson Medical Center	Williamson	Yes	2,955	11	3,210	Yes	3,527	0	3,608
94804	Rolling Hills Hospital	Williamson	No	0	0	0	No	0	0	0
95204	McFarland Hospital	Wilson	No	0	0	0	No	0	0	0
95224	University Medical Center	Wilson	Yes	2,684	4	0	Yes	5,287	4	0

Source: Tennessee Department of Health, Division of Health Statistics

Attachment C.Economic Feasibility.1

Estimated Construction Cost Letter

Turner Universal

July 17, 2013

Jim Tenpenny
Architect/Project Manager
Vanderbilt Office of Space and Facilities Planning
3319 West End Ave., Suite 200
Nashville, TN 37203-1050

RE: VUMC TVC 3rd Floor 4 OR's

Dear Mr. Tenpenny,

We have completed a Conceptual Estimate for the upcoming VUMC TVC 3rd Floor 4 OR's Project and agree that a construction budget of Four Million, Three Hundred Twenty-six Thousand, Four Hundred Eighty-two Dollars ($4,326,482) is appropriate based on the conceptual design and falls in line with similar projects in the surrounding areas.

We anticipate the construction schedule of 7 months to complete the 4 new OR's, adjacent shell space and surrounding support spaces. We appreciate the opportunity and look forward to another successful project.

Sincerely,

Brad Simmons
Project Executive
Turner Universal

CC: Paul Lawson - TCCO

Attachment C. Economic Feasibility.2.E

Funding Documentation

VANDERBILT UNIVERSITY MEDICAL CENTER

Department of Finance

August 21, 2013

Ms. Melanie M. Hill
Executive Director
Tennessee Health Services & Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Blvd
Nashville, TN 37243

Dear Ms. Hill,

This letter will confirm that Vanderbilt University by and through its Vanderbilt University Medical Center has financing resources sufficient to fund the project described in the Certificate of Need application. Funding of the project will be provided through a combination of cash reserves and/or philanthropy.

As evidence of Vanderbilt's ability to provide the necessary capital, the following information is offered.

1. As of June 30, 2012, Vanderbilt held cash & unrestricted investments with a fair market value of $4.8 billion.
2. Vanderbilt has revolving credit facilities totaling $500 million.
3. Vanderbilt has current credit ratings of Aa2/AA+/AA by Moody's Fitch/S&P.

Vanderbilt expects to finance the project with cash.

Sincerely,

Karen Nanney
Interim Senior Vice President of Finance
Vanderbilt University Medical Center

KN/jk

3319 West End Avenue
Suite 700
Nashville, TN 37203-6840

tel 615.322.2381
fax 615.343.4052
http://finweb.mc.vanderbilt.edu/

Attachment C.Economic Feasibility.6.A

List of Procedures

CAS_PRIMPROC	PMF_DESCRP
10060	INCISION & DRAINAGE; ABSCESS (10060)
10061	INCISION & DRAINAGE; ABSCESS (10061)
10080	INCISION & DRAINAGE; PILONIDAL CYST (10080)
10180	INCISION & DRAINAGE; POSTOP WOUND (10180)
11004	DEBRIDEMENT OF PERINEUM (11004)
11005	DEBRIDEMENT OF ABDOMEN (11005)
11042	WOUND DEBRIDEMENT; SUPERFICIAL (11042)
11403	BENIGN LESION EXCISION; ABDOMEN/TRUNK/EXTREMITY (11403)
11426	BENIGN LESION EXCISION; HEAD/NECK/GENITALIA (11426)
11604	MALIGNANT LESION EXCISION; ABDOMEN/TRUNK/EXTREMITY (11604)
11770	PILONIDAL CYST EXCISION (11770)
13160	CLOSURE; WOUND DEHISCENCE EXTENSIVE (13160)
15271	SKIN SUBSTITUTE GRAFT; TRUNK/EXTREMITY (15271)
15850	REMOVAL, SUTURES UNDER ANESTHESIA (OTHER THAN LOCAL), SAME SURGEON
17004	PREMALIGNANT LESION(S) DESTRUCTION (17004)
17110	BENIGN LESION(S) DESTRUCTION (17110)
19120	EXCISIONAL BREAST BX (19120)
19125	EXCISIONAL BREAST BX; NEEDLE-LOCALIZED (19125)
19260	EXCISION, CHEST WALL TUMOR W/ RIBS
19290	EXCISIONAL BREAST BX; NEEDLE-LOCALIZED (19290)
19300	MASTECTOMY FOR GYNECOMASTIA (19300)
19301	PARTIAL MASTECTOMY (19301)
19303	MASTECTOMY (19303)
19307	MODIFIED RADICAL MASTECTOMY (19307)
20103	WOUND EXPLORATION; EXTREMITY (20103)
20200	MUSCLE BX (20200)
20205	MUSCLE BX (20205)
21011	EXCISIONAL SOFT TISSUE TUMOR; FACE/SCALP (21011)
21550	BX, SOFT TISSUE, NECK/THORAX
21555	EXCISIONAL SOFT TISSUE TUMOR; NECK/THORAX (21555)
21930	EXCISION, TUMOR, SOFT TISSUE, BACK/FLANK
21931	EXCISION, TUMOR, SOFT TISUUE OF BACK OR FLANK, SUBCUTANEOUS; 3CM OR GREATER
21932	EXCISION, TUMOR, SOFT TISUUE OF BACK OR FLANK, SUBFASCIAL; LESS THAN 5CM
22900	ABDOMINAL WALL TUMOR EXCISION (22900)
22901	ABDOMINAL WALL TUMOR EXCISION (22901)
22902	ABDOMINAL WALL TUMOR EXCISION (22902)
22905	ABDOMINAL WALL TUMOR EXCISION (22905)
24065	BX, SOFT TISSUE, UPPER ARM/ELBOW AREA; SUPERFICIAL
24073	EXCISIONAL SOFT TISSUE TUMOR; UPPER EXTREMITY (24073)
24075	EXCISIONAL SOFT TISSUE TUMOR; UPPER EXTREMITY (24075)
26990	INCISION & DRAINAGE, PELVIS/HIP JOINT AREA; DEEP ABSCESS/HEMATOMA
27049	RADICAL RESECTION, TUMOR, SOFT TISSUE, PELVIS & HIP AREA
27059	RADICAL RESECTION OF TUMOR, SOFT TISSUE OF PELVIS AND HIP AREA; 5CM OR GREATER
27301	INCISION & DRAINAGE; THIGH/KNEE ABSCESS (27301)
27329	RADICAL RESECTION, TUMOR, SOFT TISSUE, THIGH/KNEE AREA
27892	DECOMPRESSION FASCIOTOMY, LEG; ANTERIOR/LATERAL COMPARTMENT W/ DEBRIDEMENT, MUSCLE/NERVE
31600	TRACHEOSTOMY (31600)
36557	INSERTION HICKMAN; UNDER 4 (36557)
36558	INSERTION HICKMAN (36558)
36561	INSERTION PORTACATH (36561)
36576	REPAIR/REPLACE PORTACATH (36576)
36590	REMOVAL PORTACATH (36590)
37609	LIGATION/BX, TEMPORAL ARTERY
38100	SPLENECTOMY (38100)
38102	SPLENECTOMY (38102)
38120	LAPAROSCOPIC SPLENECTOMY (38120)
38308	LYMPHANGIOTOMY/OTHER OPERATIONS ON LYMPHATIC CHANNELS
38500	SENTINEL LYMPH NODE BX; INGUINAL (38500)
38510	SENTINEL LYMPH NODE BX; CERVICAL (38510)
38525	SENTINEL LYMPH NODE BX; AXILLARY (38525)
38570	LAPAROSCOPIC RETROPERITONEAL LYMPH NODE BX (38570)
38745	LYMPHADENECTOMY; AXILLARY (38745)
38747	LYMPHADENECTOMY; ABDOMINAL (38747)
38765	LYMPHADENECTOMY; INGUINAL (38765)
38770	LYMPHADENECTOMY; PELVIC (38770)

CAS_PRIMPROC	PMF_DESCRP
38780	LYMPHADENECTOMY; RETROPERITONEAL (38780)
39502	NISSEN FUNDIPLICATION (39502)
39520	NISSEN FUNDIPLICATION (39520)
39541	REPAIR, DIAPHRAGMATIC HERNIA (OTHER THAN NEONATAL), TRAUMATIC; CHRONIC
40818	BUCCAL MUCOSA GRAFT (40818)
42955	PHARYNGOSTOMY (FISTULIZATION, PHARYNX, EXT, FEEDING)
43107	TOTAL/NEAR TOTAL ESOPHAGECTOMY, W/O THORACOTOMY; W/ PHARYNGOGASTROSTOMY/CERVICAL ESOPHAGOGASTROSTOMY
43112	TOTAL/NEAR TOTAL ESOPHAGECTOMY, W/ THORACOTOMY; W/ PHARYNGOGASTROSTOMY/CERVICAL ESOPHAGOGASTROSTOMY
43200	ESOPHAGOSCOPY W/WO BX (43200)
43220	ESOPHAGOSCOPY W/DILATION (43220)
43234	EGD (43234)
43235	EGD (43235)
43239	EGD (43239)
43245	EGD W/DILATION (43245)
43246	EGD W/PEG or PEJ PLACEMENT (43246)
43247	EGD; REMOVAL FOREIGN BODY (43247)
43249	EGD W/DILATION (43249)
43257	UPPER GI ENDOSCOPY; W/DELIVERY THERMAL ENERGY FOR TREATMENT OF GASTROESOPHAGEAL REFLUX DISEASE
43260	ERCP; DIAGNOSTIC (43260)
43262	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY; W/ SPHINCTEROTOMY/PAPILLOTOMY
43279	LAPAROSCOPIC HELLER MYOTOMY (43279)
43280	LAPAROSCOPIC NISSEN W/WO MESH (43280)
43281	LAPAROSCOPIC NISSEN W/WO MESH (43281)
43282	LAPAROSCOPIC NISSEN W/WO MESH (43282)
43324	NISSEN FUNDIPLICATION (43324)
43326	NISSEN FUNDIPLICATION (43326)
43327	NISSEN FUNDIPLICATION (43327)
43332	PARAESOPHAGEAL HERNIA REPAIR (43332)
43333	REPAIR, PARAESOPHAGEAL HIATAL HERNIS, VIA LAPAROTOMY WITH IMPLANTATION OF MESH/PROTHESIS
43340	ESOPHAGOJEJUNOSTOMY (WITHOUT TOTAL GASTRECTOMY); ABDOMINAL APPROACH
43360	GI RECONSTRUCTION, PRIOR ESOPHAGECTOMY; W/ STOMACH, W/WO PYLOROPLASTY
43620	GASTRECTOMY (43620)
43621	GASTRECTOMY (43621)
43631	PARTIAL GASTRECTOMY (43631)
43632	PARTIAL GASTRECTOMY (43632)
43633	PARTIAL GASTRECTOMY (43633)
43644	LAPAROSCOPIC GASTRIC BYPASS (43644)
43647	LAPAROSCOPIC GASTRIC PACER (43647)
43653	LAPAROSCOPIC GASTRIC TUBE PLACEMENT (43653)
43659	UNLISTED PROC, LAPAROSCOPY, STOMACH
43760	EGD W/PEG or PEJ PLACEMENT (43760)
43770	LAPAROSCOPIC GASTRIC BAND PLACEMENT (43770)
43772	LAPAROSCOPIC REVISION/REMOVAL GASTRIC BAND (43772)
43774	LAPAROSCOPIC REVISION/REMOVAL GASTRIC BAND (43774)
43775	LAPAROSCOPIC VERTICAL SLEEVE GASTRECTOMY (43775)
43810	GASTRODUODENOSTOMY
43820	GASTROJEJUNOSTOMY (43820)
43830	GASTROSTOMY (43830)
43846	GASTRIC SLEEVE (43846)
43860	REVISION, GASTROJEJUNAL ANASTOMOSIS W/ RECONSTRUCTION W/WO PART GASTRECT/INTESTINE RESECT; W/O VAGOTOMY
43870	CLOSURE; GASTROSTOMY (43870)
43880	CLOSURE; GASTROSTOMY (43880)
43886	GASTRIC RESTRICTIVE PROCEDURE; COMPONENT ONLY (43886)
44005	LYSIS OF ADHESIONS (44005)
44015	INSERTION JEJUNOSTOMY TUBE (44015)
44055	EXPLORATORY LAPAROTORY FOR VOLVULUS (44055)
44110	EXCISION, 1+ LESION, SMALL/LARGE INTESTINE; SINGLE ENTEROTOMY
44120	SMALL BOWEL RESECTION (44120)
44128	SMALL BOWEL RESECTION (44128)
44139	PARTIAL COLECTOMY (44139)
44140	PARTIAL COLECTOMY (44140)
44141	PARTIAL COLECTOMY (44141)
44145	LOWER ANTERIOR RESECTION (44145)
44146	LOWER ANTERIOR RESECTION (44146)
44150	COLECTOMY (44150)

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44155	COLECTOMY (44155)
44157	COLECTOMY W/ILEOANAL POUCH (44157)
44158	COLECTOMY W/ILEOANAL POUCH (44158)
44160	PARTIAL COLECTOMY (44160)
44180	LAPAROSCOPIC LYSIS OF ADHESIONS (44180)
44187	LAPAROSCOPIC ILEOSTOMY (44187)
44188	LAPAROSCOPIC COLOSTOMY (44188)
44202	LAPAROSCOPIC SMALL BOWEL RESECTION (44202)
44204	LAPAROSCOPIC PARTIAL BOWEL RESECTION (44204)
44205	LAPAROSCOPIC PARTIAL BOWEL RESECTION (44205)
44206	LAPAROSCOPIC PARTIAL BOWEL RESECTION (44206)
44207	LAPAROSCOPIC LOWER ANTERIOR RESECTION (44207)
44208	LAPAROSCOPIC LOWER ANTERIOR RESECTION (44208)
44210	LAPAROSCOPIC COLECTOMY (44210)
44211	LAPAROSCOPIC COLECTOMY W/ILEOANAL POUCH (44211)
44212	LAPAROSCOPIC COLECTOMY W/ILEOANAL POUCH (44212)
44238	UNLISTED LAPAROSCOPY PROCEDURE, INTESTINE (EXCEPT RECTUM)
44310	ILEOSTOMY (44310)
44312	REVISION ILEOSTOMY (44312)
44314	REVISION ILEOSTOMY (44314)
44320	COLOSTOMY (44320)
44340	REVISION COLOSTOMY (44340)
44345	REVISION COLOSTOMY (44345)
44346	PARASTOMAL HERNIA REPAIR (44346)
44385	POUCHOSCOPY; DIAGNOSTIC W/WO BX (44385)
44620	CLOSURE; ILEOSTOMY (44620)
44820	EXCISION, LESION, MESENTERY (SEP PROC)
44970	LAPAROSCOPIC APPENDECTOMY (44970)
45000	INCISION & DRAINAGE; PELVIC ABSCESS (45000)
45100	ANOSCOPY W/WO BX (45100)
45110	ABDOMINOPERINEAL RESECTION (45110)
45111	PROCTECTOMY (45111)
45113	PROCTECTOMY (45113)
45119	PROCTECTOMY (45119)
45123	PROCTECTOMY (45123)
45126	PELVIC EXENTERATION (45126)
45130	PROLAPSE RECTUM REPAIR (45130)
45136	EXCISION, ILEOANAL RESERVOIR W ILEOSTOMY
45160	RETRORECTAL MASS EXCISION (45160)
45171	TRANSANAL MASS EXCISION (45171)
45330	SIGMOIDOSCOPY W/WO BX (45330)
45378	COLONOSCOPY; DIAGNOSTIC W/WO BX (45378)
45395	LAPAROSCOPIC ABDOMINOPERINEAL RESECTION (45395)
45540	ABDOMINAL RECTOPEXY (45540)
45560	RECTOCELE REPAIR; ABD APPROACH (45560)
45800	CLOSURE; RECTOURETHRAL FISTULA (MALE) (45800)
45910	ANOSCOPY W/DILATION (45910)
45990	ANOSCOPY; DIAGNOSTIC (45990)
45999	UNLISTED PROC, RECTUM
46020	ANOSCOPY W/INSERTION OF SETON (46020)
46040	INCISION & DRAINAGE; PERIRECTAL ABSCESS (46040)
46080	FISSURECTOMY W/WO SPHINCTEROTOMY (46080)
46220	ANOSCOPY; REMOVAL OF LESION (46220)
46221	HEMORRHOIDECTOMY (46221)
46250	HEMORRHOIDECTOMY (46250)
46255	HEMORRHOIDECTOMY (46255)
46270	ANOSCOPY W/INSERTION OF SETON (46270)
46275	ANOSCOPY W/INSERTION OF SETON (46275)
46280	ANOSCOPY W/INSERTION OF SETON (46280)
46288	CLOSURE; FISTULA W/RECTAL ADV FLAP (46288)
46505	ANOSCOPY W/BOTOX INJECTION (46505)
46600	ANOSCOPY W/WO BX (46600)
46604	ANOSCOPY W/DILATION (46604)
46606	ANOSCOPY W/WO BX (46606)
46706	ANOSCOPY W/FIBRIN GLUE (46706)

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46750	SPHINCTEROPLASTY (46750)
46922	ANAL LESION EXCISION (46922)
47000	HEPATIC BX (47000)
47100	HEPATIC BX (47100)
47120	PARTIAL HEPATECTOMY (47120)
47122	HEPATECTOMY, RESECTION, LIVER; TRISEGMENTECTOMY
47125	HEPATECTOMY; RESECTION LEFT (47125)
47130	HEPATECTOMY; RESECTION RIGHT (47130)
47379	UNLISTED LAPAROSCOPIC PROCEDURE, LIVER
47420	CHOLEDOCHOTOMY/OSTOMY W/ EXPLORE/DRAIN/REMOVAL CALCULUS; W/O TRANSDUODENAL SPHINCTEROTOMY/PLASTY
47562	LAPAROSCOPIC CHOLECYSTECTOMY W/WO IOC (47562)
47563	LAPAROSCOPIC CHOLECYSTECTOMY W/WO IOC (47563)
47564	LAPAROSCOPIC BILE DUCT EXPLORATION (47564)
47600	CHOLECYSTECTOMY W/WO IOC (47600)
47605	CHOLECYSTECTOMY W/WO IOC (47605)
47612	BILE DUCT EXPLORATION (47612)
47780	BILE DUCT REPAIR (47780)
48105	DEBRIDEMENT OF PANCREAS (48105)
48120	EXCISION PANCREATIC LESION (48120)
48140	DISTAL PANCREATECTOMY (48140)
48148	AMPULLECTOMY (48148)
48150	WHIPPLE PROCEDURE (48150)
48153	WHIPPLE PROCEDURE (48153)
48154	PANCREATECTOMY (PYLORUS SPARING, WHIPPLE); W/O PANCREATOJEJUNOSTOMY
48155	PANCREATECTOMY (48155)
48510	PANCREATIC PSEUDOCYST; EXTERNAL DRAINAGE (48510)
48511	EXT DRAINAGE, PSEUDOCYST, PANCREAS; PERCUTANEOUS
48520	ANASTOMOSIS PANCREATIC CYST; DIRECT (48520)
48548	PUESTOW (PANCREATICOJEJUNOSTOMY) (48548)
48999	UNLISTED PROC, PANCREAS
49000	EXPLORATORY LAPAROTOMY (49000)
49002	LAPAROTOMY FOR OPEN ABD (49002)
49010	INCISION & DRAINAGE; PERITONEAL ABSCESS (49010)
49203	ABDOMINAL TUMOR EXCISION & DEBULKING (49203)
49204	ABDOMINAL TUMOR EXCISION & DEBULKING (49204)
49205	ABDOMINAL TUMOR EXCISION & DEBULKING (49205)
49215	EXCISION, PRESACRAL/SACROCOCCYGEAL TUMOR
49320	EXPLORATORY LAPAROSCOPY (49320)
49321	EXPLORATORY LAPAROSCOPY (49321)
49329	UNLISTED PROC, LAPAROSCOPY, ABDOMEN, PERITONEUM & OMENTUM
49425	INSERTION, PERITONEAL-VENOUS SHUNT
49440	EGD W/PEG or PEJ PLACEMENT (49440)
49441	EGD W/PEG or PEJ PLACEMENT (49441)
49451	EGD W/PEG or PEJ PLACEMENT (49451)
49452	EGD W/PEG or PEJ PLACEMENT (49452)
49505	INGUINAL HERNIORRAPHY W/WO MESH (49505)
49507	INGUINAL HERNIORRAPHY W/WO MESH (49507)
49520	INGUINAL HERNIORRAPHY W/WO MESH (49520)
49521	INGUINAL HERNIORRAPHY W/WO MESH (49521)
49550	REPAIR, INITIAL FEMORAL HERNIA, ANY AGE; REDUCIBLE
49560	INCISIONAL HERNIORRAPHY W/WO MESH (49560)
49561	INCISIONAL HERNIORRAPHY W/WO MESH (49561)
49565	INCISIONAL HERNIORRAPHY W/WO MESH (49565)
49566	INCISIONAL HERNIORRAPHY W/WO MESH (49566)
49568	IMPLANTATION OF MESH (49568)
49570	EPIGASTRIC HERNIORRAPHY W/WO MESH (49570)
49585	UMBILICAL HERNIORRAPHY W/WO MESH (49585)
49587	UMBILICAL HERNIORRAPHY W/WO MESH (49587)
49590	INCISIONAL HERNIORRAPHY W/WO MESH (49590)
49650	LAPAROSCOPIC INGUINAL HERNIORRAPHY W/WO MESH (49650)
49651	LAPAROSCOPIC INGUINAL HERNIORRAPHY W/WO MESH (49651)
49652	LAPAROSCOPIC INCISIONAL HERNIORRAPHY W/WO MESH (49652)
49654	LAPAROSCOPIC INCISIONAL HERNIORRAPHY W/WO MESH (49654)
49655	LAPAROSCOPIC INCISIONAL HERNIORRAPHY W/WO MESH (49655)
49656	LAPAROSCOPIC INCISIONAL HERNIORRAPHY W/WO MESH (49656)

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49657	LAPAROSCOPIC INCISIONAL HERNIORRAPHY W/WO MESH (49657)
49900	SUTURE, SECONDARY, ABDOMINAL WALL, EVISCERATION/DEHISCENCE
49905	ABDOMINAL OMENTAL FLAP (49905)
50010	NEPHRECTOMY (50010)
50081	PERCUTANEOUS NEPHROLITHOTOMY (50081)
50220	NEPHRECTOMY (50220)
50230	NEPHRECTOMY (50230)
50234	NEPHRO-URETERECTOMY (50234)
50236	NEPHRO-URETERECTOMY (50236)
50240	PARTIAL NEPHRECTOMY (50240)
50380	RENAL AUTOTRANSPLANTATION, REIMPLANTATION, KIDNEY
50385	REMOVAL AND REPLACEMENT OF INTERNALLY DWELLING URETERAL STENT VIA TRANSURETHRAL APPROACH, W/O CYSTOSCOPY
50392	PERCUTANEOUS NEPHROSTOMY; TUBE PLACEMENT (50392)
50393	PERCUTANEOUS NEPHROSTOMY; STENT PLACEMENT (50393)
50541	LAPAROSCOPIC ABLATION RENAL MASS (50541)
50542	LAPAROSCOPIC ABLATION RENAL MASS (50542)
50543	LAPAROSCOPIC PARTIAL NEPHRECTOMY (50543)
50544	LAPAROSCOPIC PYELOPLASTY (50544)
50545	LAPAROSCOPIC NEPHRECTOMY (50545)
50546	LAPAROSCOPIC NEPHRECTOMY (50546)
50548	LAPAROSCOPIC NEPHRO-URETERECTOMY (50548)
50551	PERCUTANEOUS NEPHROLITHOTOMY SECOND LOOK (50551)
50553	RENAL ENDOSCOPY THROUGH NEPHROSTOMY/PYELOSTOMY; W/ CATHETERIZATION, W/WO DILATION
50561	PERCUTANEOUS NEPHROLITHOTOMY SECOND LOOK (50561)
50590	SHOCKWAVE LITHOTRIPSY (50590)
50605	CYSTOSCOPY; URETERAL STENTS (50605)
50650	URETERECTOMY (50650)
50727	REVISION URINARY CUTANEOUS ANASTOMOSIS (50727)
50780	REIMPLANT URETER (50780)
50785	REIMPLANT URETER (50785)
50820	ILEAL CONDUIT (50820)
50825	CONTINENT URINARY OSTOMY (50825)
50840	REPLACEMENT, ALL/PART, URETER, INTESTINE SEGMENT, W/ INTESTINE ANASTOMOSIS
50947	LAPAROSCOPIC REIMPLANT URETER (50947)
51040	CYSTOTOMY; TUBE PLACEMENT (51040)
51050	CYSTOTOMY; REMOVAL BLADDER STONE (51050)
51102	INSERTION SUPRAPUBIC CATHETER (51102)
51500	URACHAL CYST EXCISION W/WO UMBILICAL HERNIORRAPHY (51500)
51550	PARTIAL CYSTECTOMY (51550)
51565	CYSTECTOMY, PARTIAL; W/ REIMPLANTATION, URETER(S) INTO BLADDER (URETERONEOCYSTOSTOMY)
51590	CYSTECTOMY W/ILEAL CONDUIT (51590)
51595	CYSTECTOMY W/ILEAL CONDUIT (51595)
51596	CYSTECTOMY W/CONTINENT DIVERSION; NEOBLADDER (51596)
51610	CYSTOGRAM (51610)
51702	INSERTION CATHETER (51702)
51705	CHANGE, CYSTOSTOMY TUBE; SIMPLE
51715	CYSTOSCOPY W/INJECTION (51715)
51900	CLOSURE; VESICOVAGINAL FISTULA ABD APPROACH (51900)
51960	BLADDER AUGMENTATION (51960)
52000	CYSTOSCOPY (52000)
52001	CYSTOSCOPY W/EVAC CLOTS (52001)
52005	CYSTOSCOPY W/INSERTION OF CATHETERS (52005)
52204	CYSTOSCOPY W/BX (52204)
52214	TRANSURETHRAL RESECTION BLADDER TUMOR (TURBT) (52214)
52224	TRANSURETHRAL RESECTION BLADDER TUMOR (TURBT) (52224)
52234	TRANSURETHRAL RESECTION BLADDER TUMOR (TURBT) (52234)
52235	TRANSURETHRAL RESECTION BLADDER TUMOR (TURBT) (52235)
52260	CYSTOSCOPY W/DILATION (52260)
52275	CYSTOSCOPY W/DVI URETHROTOMY (52275)
52276	CYSTOSCOPY W/DVI URETHROTOMY (52276)
52281	CYSTOSCOPY; URETHRAL STRICTURE (52281)
52282	CYSTOSCOPY; URETERAL STENTS (52282)
52287	CYSTOURETHROSCOPY W/INJECTION(S) FOR CHEMODENERVATION OF THE BLADDER
52310	CYSTOSCOPY; REMOVAL OF STENT (52310)
52315	CYSTOSCOPY; REMOVAL OF STENT (52315)

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52317	CYSTOSCOPY; REMOVAL BLADDER STONE (52317)
52318	CYSTOSCOPY; REMOVAL BLADDER STONE (52318)
52320	URETEROSCOPY W/WO LITHOTRIPSY (52320)
52325	CYSTOURETHROSCOPY; W/ FRAGMENTATION, URETERAL CALCULUS
52327	CYSTOSCOPY W/DEFLUX INJECTION (52327)
52332	CYSTOSCOPY; URETERAL STENTS (52332)
52334	CYSTOSCOPY; URETERAL STENTS (52334)
52342	URETEROSCOPY W/WO LITHOTRIPSY (52342)
52344	URETEROSCOPY W/URETERAL STRICTURE TX (52344)
52351	URETEROSCOPY DIAGNOSTIC (52351)
52352	URETEROSCOPY W/WO LITHOTRIPSY (52352)
52353	URETEROSCOPY W/WO LITHOTRIPSY (52353)
52354	URETEROSCOPY W/WO RENAL BX (52354)
52355	CYSTOURETHROSCOPY W/ URETEROSCOPY &/OR PYELOSCOPY; W/ RESECTION OF URETERAL OR RENAL PELVIC TUMOR
52450	TRANSURETHRAL INCISION OF PROSTATE (52450)
52500	TRANSURETHRAL RESECTION BLADDER NECK (52500)
52601	TRANSURETHRAL RESECTION PROSTATE (TURP) (52601)
52640	TRANSURETHRAL RESECTION BLADDER NECK (52640)
52649	LASER ENUCLEATION OF PROSTATE (HoLEP) (52649)
53010	URETHROSTOMY (53010)
53200	URETHRA BX (53200)
53215	URETHRECTOMY (53215)
53230	URETHRAL DIVERTICULECTOMY (53230)
53270	SKENES GLANDS EXCISION (53270)
53410	URETHROPLASTY; MALE ANTERIOR (53410)
53415	URETHROPLASTY; MALE POSTERIOR (53415)
53430	URETHROPLASTY; FEMALE (53430)
53440	SLING; MALE (53440)
53445	INSERTION ARTIFICIAL URINARY SPHINCTER (AUS) (53445)
53446	REMOVAL ARTIFICIAL URINARY SPHINCTER (AUS) (53446)
53447	REVISION ARTIFICIAL URINARY SPHINCTER (AUS) (53447)
53448	REMOVAL/REPLACEMENT, INFLATABLE URETHRAL/BLADDER NECK W PUMP, RESERVOIR & CUFF THRU INFECTED FIELD W I&D
53500	URETHROLYSIS; VAGINAL APPROACH (53500)
53600	URETHRAL DILATION (53600)
53855	INSERTION OF A TEMPORARY PROSTATIC URETHRAL STENT, INCLUDING URETHRAL MEASUREMENT
54015	INCISION & DRAINAGE; PENIS (54015)
54057	PENILE LESION EXCISION W/LASER (54057)
54060	PENILE LESION EXCISION (54060)
54100	PENILE BX (54100)
54105	PENILE BX (54105)
54110	PLAQUE INCISION & GRAFT (PEYRONIES) (54110)
54111	EXCISION, PENILE PLAQUE (PEYRONIE DISEASE); W/ GRAFT TO 5 CM IN LENGTH
54112	PLAQUE INCISION & GRAFT (PEYRONIES) (54112)
54120	PENECTOMY (54120)
54125	PENECTOMY (54125)
54150	CIRCUMCISION (54150)
54161	CIRCUMCISION (54161)
54163	CIRCUMCISION REVISION (54163)
54360	CHORDEE STRAIGHTENING (54360)
54405	INSERTION PENILE PROTHESIS (IPP) (54405)
54406	REMOVAL PENILE PROTHESIS (54406)
54408	REVISION PENILE PROTHESIS (54408)
54410	REVISION PENILE PROTHESIS (54410)
54411	REMOVAL/REPLACEMENT, COMPONENTS, MULTICOMPONENT INFLATABLE PENILE PROSTHESIS, INFECTED W I&D
54430	PRIAPISM REPAIR (54430)
54520	ORCHIECTOMY; SCROTAL APPROACH (54520)
54522	PARTIAL ORCHIECTOMY (54522)
54530	ORCHIECTOMY; INGUINAL APPROACH (54530)
54535	ORCHIECTOMY; INGUINAL APPROACH (54535)
54700	INCISION & DRAINAGE; SCROTUM (54700)
54830	EPIDIDYMECTOMY (54830)
54840	SPERMATOCELECTOMY (54840)
54860	EPIDIDYMECTOMY (54860)
55040	HYDROCELECTOMY (55040)
55100	INCISION & DRAINAGE; SCROTUM (55100)

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55150	RESECTION; SCROTUM (55150)
55250	VASECTOMY (55250)
55530	VARICOCELECTOMY (55530)
55700	PROSTATE BX W/ULTRASOUND (55700)
55706	PROSTATE BX W/ULTRASOUND (55706)
55842	PROSTATECTOMY, RETROPUBIC RADICAL W/WO NERVE SPARING; W/ LIMITED LYMPH NODE BX
55845	RETROPUBIC PROSTATECTOMY (55845)
55866	LAPAROSCOPY, SURGICAL PROSTATECTOMY, RETROPUBIC RADICAL, INCLUDING NERVE SPARING
55873	CYROSURGICAL ABLATION; PROSTATE (55873)
55875	BRACHYTHERAPY PROSTATE (55875)
55899	UNLISTED PROC, MALE GENITAL SYSTEM
57135	VAGINAL/CERVICAL MASS EXCISION (57135)
57240	CYSTOCELE REPAIR; VAGINAL APPROACH (57240)
57288	SLING; STRESS INCONTINENCE (57288)
57295	REVISION VAGINAL MESH; VAG APPROACH (57295)
57308	CLOSURE; RECTOVAGINAL FISTULA VAGINAL APPROACH (57308)
57330	CLOSURE; VESICOVAGINAL FISTULA VAGINAL APPROACH (57330)
57410	PELVIC EUA (57410)
57415	REMOVAL VAGINAL MESH (57415)
58952	EXPLORATORY LAPAROTOMY; TUMOR DEBULKING W/WO TAH BSO (58952)
60540	ADRENALECTOMY (60540)
60650	LAPAROSCOPIC ADRENALECTOMY TRANSABDOMINAL (60650)
64575	INCISION, IMPLANTATION, NEUROSTIMULATOR ELECTRODES; PERIPHERAL NERVE, EXCEPT SACRAL NERVE
64580	INCISION, IMPLANTATION, NEUROSTIMULATOR ELECTRODES; NEUROMUSCULAR
64581	INSERTION INTERSTIM; STAGE 1 (64581)
64585	REMOVAL/REVISION INTERSTIM; STAGE 1 (64585)
64590	INSERTION INTERSTIM; STAGE 2 (64590)
64595	REMOVAL/REVISION INTERSTIM; STAGE 2 (64595)
64640	CYSTOSCOPY W/BOTOX INJECTION (64640)
74400	RETROGRADE PYELOGRAM (74400)
74420	RETROGRADE PYELOGRAM (74420)
74425	RETROGRADE PYELOGRAM (74425)
74430	CYSTOGRAM (74430)
76940	LAPAROSCOPIC ABLATION RENAL MASS (76940)
76942	RADIOLOGY ULTRASOUND BX (76942)
76965	BRACHYTHERAPY PROSTATE (76965)
95972	INSERTION INTERSTIM; STAGE 2 (95972)
97597	DEBRIDEMENT, REMOVAL OF DEVITALIZED TISSUE FROM WOUND(S);SURFACE AREA LESS THAN OR EQUAL TO 20CM
97606	NEGATIVE PRESSURE WOUND THERAPY (97606)
0184T	TRANSANAL RECTAL TUMOR EXCISION (TEM) (0184T)
36561P	INSERTION PORTACATH (36561P)
38571R	LAPAROSCOPIC ROBOTIC BILAT PELVIC LYMPHADENECTOMY (38571R)
38765B	LYMPHADENECTOMY; INGUINAL (38765B)
39502L	LAPAROSCOPIC NISSEN W/WO MESH (39502L)
43262TG	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY; W/ SPHINCTEROTOMY/PAPILLOTOMY-TRANSGASTRIC
43280R	LAPAROSCOPIC ROBOTIC NISSEN (43280R)
43280T	LAPAROSCOPIC TOUPET (43280T)
43644R	LAPAROSCOPIC ROBOTIC GASTRIC BYPASS (43644R)
43647R	LAPAROSCOPIC ROBOTIC GASTRIC PACER (43647R)
43659SR	LAPAROSCOPY, STOMACH, BYPASS SLEEVE; ROBOTIC
43771R	LAPAROSCOPIC GASTRIC RESTRICTIVE PROCEDURE,REVISION,ADJUSTABLE GASTRIC RESTRICTIVE DEVICE COMPONENT ROBOTIC
43774R	LAPAROSCOPIC ROBOTIC REMOVAL GASTRIC BAND (43774R)
43775R	LAPAROSCOPIC ROBOTIC VERTICAL SLEEVE GASTRECTOMY (43775R)
43865R	REVISION, GASTROJEJUNAL ANASTOMOSIS W/ RECONSTRUCTION W/WO PART GASTRECT/BOWEL RESECT; W/ VAGOTOMY ROBOTIC
44207R	ROBOTIC LOWER ANTERIOR RESECTION (44207R)
44208R	ROBOTIC LOWER ANTERIOR RESECTION (44208R)
45110R	LAPAROSCOPIC ROBOTIC ABDOMINOPERINEAL RESECTION (45110R)
45126R	PELVIC EXENTERATION, W/ PROCTECTOMY/PELVIC ORGAN REMOVAL, ANY COMBINATION ROBOTIC
45395R	LAPAROSCOPIC ROBOTIC ABDOMINOPERINEAL RESECTION (45395R)
45397R	LAPAROSCOPIC ROBOTIC ABDOMINOPERINEAL RESECTION (45397R)
47563R	LAPAROSCOPIC ROBOTIC CHOLECYSTECTOMY W/WO IOC (47563R)
48140L	LAPAROSCOPIC DISTAL PANCREATECTOMY W/WO SPLENECTOMY (48140L)
49000T	TRAUMA EXPLORATORY LAPAROTOMY (GENERAL)
50240R	LAPAROSCOPIC PARTIAL NEPHRECTOMY (50240R)
50543R	LAPAROSCOPIC ROBOTIC PARTIAL NEPHRECTOMY (50543R)

CAS_PRIMPROC	PMF_DESCRP
50544R	LAPAROSCOPIC ROBOTIC PYELOPLASTY (50544R)
50545R	LAPAROSCOPIC ROBOTIC NEPHRECTOMY (50545R)
50548R	LAPAROSCOPIC ROBOTIC NEPHRO-URETERECTOMY (50548R)
50948R	LAPAROSCOPIC ROBOTIC REIMPLANT URETER (50948R)
51590R	LAPAROSCOPIC ROBOTIC CYSTECTOMY W/ILEAL CONDUIT (51590R)
51595R	LAPAROSCOPIC ROBOTIC CYSTECTOMY W/ILEAL CONDUIT (51595R)
51596R	LAPAROSCOPIC ROBOTIC CYSTECTOMY W/CONTINENT DIVERSION (51596R)
51900R	LAPAROSCOPIC ROBOTIC CLOSURE VESICOVAGINAL FISTULA (51900R)
52235BL	TRANSURETHRAL RESECTION BLADDER TUMOR (TURBT) BLUE LIGHT (52235BL)
55866R	LAPAROSCOPIC ROBOTIC PROSTATECTOMY (RALP) (55866R)
57280R	LAPAROSCOPIC ROBOTIC COLPOPEXY (57280R)
60650R	LAPAROSCOPIC ADRENALECTOMY TRANSABDOMINAL ROBOTIC (60650R)
64590R	LAPAROSCOPIC ROBOTIC GASTRIC GENERATOR (64590R)
64640BA	CYSTOSCOPY W/BOTOX INJECTION (64640BA)
64752R	TRANSECTION/AVULSION; VAGUS NERVE (VAGOTOMY), TRANSTHORACIC ROBOTIC
CANCEL	CASE CANCELLED AFTER ADMISSION TO OR (CANCEL)
ROBOT07	ROBOT INSTRUMENTS AND SUPPLIES (ROBOT07)
ROBOT11	ROBOT INSTRUMENTS AND SUPPLIES . (ROBOT11)

Attachment C.Economic Feasibility.10

Vanderbilt University Medical Center Financial Statements

2012

2012 FINANCIAL REPORT

VANDERBILT UNIVERSITY

Contents

Letter from the Chancellor

The beginning of a new fiscal year provides an interesting vantage point from which to peer at Vanderbilt. As we reflect on the previous year, we are very pleased with our results and progress in all areas. When measured against the global and political environment, we are even more pleased.

Hard work and fiduciary discipline provide Vanderbilt a strong foundation from which to navigate the road ahead. We completed the year with a positive return and annual operating results of $158 million. This promising start for FY2013 allows the university to invest in its mission through initiatives that include retention and recruitment of world-class faculty, advancement of the residential colleges program, expansion for our hospitals and clinics, and enhancements to athletic facilities.

As Vanderbilt has made these significant investments, we remain committed to responsible growth that is aligned with our mission and our means. As we celebrate our achievements, we are ever mindful of the importance of responsibly managing our resources to retain our enviable standing among the country's top research universities.

Chief among the factors that have vaulted Vanderbilt to this position is a deep commitment to accepting students on the basis of talent and academic achievement, without regard to their ability to pay. Vanderbilt is one of only a handful of institutions who meet 100 percent of undergraduates' demonstrated financial need with grant assistance – and no loans. Additionally, to ensure that the rising rate of tuition does not deter students in their pursuit of a college education, the undergraduate tuition increase was held to 1.9 percent – Vanderbilt's lowest increase in over 25 years and the lowest among all of our peers.

These principles of meritocracy and providing opportunity are supported by the generous giving of Vanderbilt alumni, parents, faculty, staff, and friends. Thanks to increased philanthropy from alumni and a record high number of undergraduate donors, all areas of the university – from scholarships and the undergraduate experience, to faculty chairs and patient care – were strengthened in FY2012.

The unique combination of outstanding faculty; cutting-edge research within a liberal arts educational environment; investments in all aspects of the student experience; and strenuous efforts to provide financial aid for students with need has pushed the demand for the Vanderbilt experience to an all-time high. The university saw an incredible increase in undergraduate, graduate, and professional student applications, including 28,348 applications received for the Class of 2016. This steady climb is up 14 percent from the previous year and 119 percent from 2007. Similarly, we saw our tenth consecutive record year for the number of graduate applications.

Particularly noteworthy in a year of declines in governmental health care reimbursement and funding from the National Institutes of Health, Vanderbilt University Medical Center wrapped up FY2012 with continued strong performance. Likewise, the university's research enterprise continued its decade-long trajectory of growing faster than the federal funding rate. This past fiscal year, we secured $572 million in sponsored research awards, a decrease of only 2.6 percent from FY2011 despite far larger reductions in funding rates from public and private sponsors. Vanderbilt remains in the very highest tier for receipt of peer-reviewed NIH-funded research grants among all universities and colleges.

Collectively, these investments burnish Vanderbilt's reputation as a powerful research university set within a caring, supportive environment that seeks to bring out the best in each student and provide the finest in personalized care for each patient. Having just completed my 25th year at Vanderbilt University, I believe more passionately than ever that the future of higher education, our great nation, and humankind rests strongly and responsibly with the great research universities like Vanderbilt. Through innovative discoveries, exemplary scholarship, strategic planning, and careful stewardship, we are well positioned to accept this formidable challenge, and we embrace the opportunity with a keen sense of optimism.

Sincerely,

Nicholas S. Zeppos
Chancellor

Vanderbilt University Statistics

	2011/2012	2010/2011	2009/2010	2008/2009	2007/2008
STUDENTS					
Undergraduate	6,817	6,879	6,794	6,637	6,532
Graduate and professional	6,019	5,835	5,712	5,455	5,315
Total fall enrollment	12,836	12,714	12,506	12,092	11,847
Undergraduate admissions					
Applied	24,837	21,811	19,353	16,944	12,910
Accepted	4,078	3,914	3,899	4,292	4,237
Enrolled	1,601	1,600	1,599	1,569	1,672
Selectivity	16.4%	17.9%	20.1%	25.3%	32.8%
Yield	39.3%	40.9%	41.0%	36.6%	39.5%
Degrees conferred					
Baccalaureate	1,673	1,735	1,583	1,568	1,542
Master's	1,432	1,252	1,280	1,235	1,081
M.D.	99	97	118	103	94
Other doctoral	516	556	515	477	519
Total degrees conferred	3,720	3,640	3,496	3,383	3,236
Undergraduate six-year graduation rate	92.2%	91.9%	90.6%	90.7%	89.4%
Undergraduate tuition	$ 40,320	$ 38,952	$ 37,632	$ 36,100	$ 34,414
% increase over prior year	3.5%	3.5%	4.2%	4.9%	5.5%
HOSPITALS AND CLINICS					
Licensed beds	985	916	916	836	836
Inpatient days	285,270	282,547	272,731	265,733	267,947
Discharges	53,818	52,453	51,874	51,575	51,831
Average daily census	782	774	747	728	732
Average length of stay (days)	5.3	5.4	5.3	5.2	5.2
Average occupancy level	83.6%	84.5%	83.6%	87.1%	87.6%
Hospital surgical operations - inpatient	22,183	22,246	21,702	21,283	20,383
Hospital surgical operations - outpatient	28,815	25,650	23,790	18,597	19,574
Ambulatory visits	1,725,901	1,586,395	1,450,196	1,266,255	1,178,841
Emergency visits	114,051	109,987	108,398	102,631	102,998
LifeFlight (helicopter) missions	2,550	2,203	2,152	2,112	2,458
Case mix index	1.90	1.93	1.93	1.89	1.81
FACULTY AND STAFF					
Full-time faculty	3,551	3,448	3,309	3,131	2,997
Full-time staff	20,119	19,192	18,089	17,160	16,246
Part-time faculty	439	396	424	402	351
Part-time staff	768	798	683	676	666
Total headcount	24,877	23,834	22,505	21,369	20,260
RESEARCH EXPENDITURES FUNDING (in thousands)					
Federal grants and contracts	$ 310,786	$ 320,211	$ 279,282	$ 250,431	$ 244,117
Nonfederal grants, contracts, and other	57,625	54,694	57,880	64,061	60,019
Facilities and administrative costs recovery	142,663	140,205	125,526	114,509	110,847
Institutional resources, including cost sharing	48,042	47,959	48,115	45,990	46,455
Total research expenditures	$ 559,116	$ 563,069	$ 510,803	$ 474,991	$ 461,438
ENDOWMENT					
Market value (in thousands)	$ 3,360,036	$ 3,375,153	$ 3,007,607	$ 2,833,614	$ 3,495,439
Endowment return	1.3%	13.6%	8.9%	-16.3%	2.1%
Endowment per student	$ 261,767	$ 265,467	$ 240,493	$ 234,338	$ 295,048
Endowment payout (spending formula)	4.4%	4.8%	5.2%	4.7%	3.8%
Endowment payout (strategic initiatives)	-	-	0.1%	0.1%	0.2%
Total endowment payout	4.4%	4.8%	5.3%	4.8%	4.0%

Financial Overview

As Vanderbilt continues to operate in an environment with increasing regulatory requirements as well as national and international uncertainty, financial diligence remains vital to carrying out the university's mission. Vanderbilt is dedicated to focusing resources on areas with the highest strategic importance for the university's future. We remain committed to striking the right balance of fiscal restraint with continued aggressive investments in students, faculty, and staff. In support of this commitment through coordinated efforts across the university as a whole, Vanderbilt again strengthened its financial foundation with positive operating results in fiscal 2012.

Several key factors contributed to Vanderbilt's positive financial performance during fiscal 2012. The university's net operating results of $158 million continue to enhance our strong liquidity position. Moreover, we have paid down a significant amount of debt. Vanderbilt's medical center continues to grow and thrive in a rapidly changing environment by providing world-class health care services with continued positive financial performance.

Undergraduate and graduate applications continue to grow. The record size and strength of the applications received demonstrate the increasing value students are placing on a Vanderbilt education. The number of applications for the fall of 2011 grew 13.9% to a total of 24,837 with a selectivity rate of 16.4% compared to 17.9% in fall 2010—and the fall 2012 selectivity rate was at a record level of 14.2%.

After successful completion of the *Shape the Future* campaign in fiscal 2011, fundraising remains strong and, despite federal budget constraints, Vanderbilt's research enterprise remains solid. Vanderbilt's commitment to scholarly research, informed and creative teaching, and service to the public continues to attract outstanding faculty members, enhancing the educational experience for all Vanderbilt students.

Investments in the future of Vanderbilt and its mission would not be possible without a strong financial foundation. The details of Vanderbilt's financial performance for fiscal 2012 below demonstrate the continued commitment of the university to excellence and providing outstanding opportunities for the future.

Financial Position

As of June 30, 2012, Vanderbilt's financial position consisted of assets totaling $7,471 million and liabilities totaling $2,452 million, resulting in net assets of $5,019 million.

Summary of Financial Position
as of June 30, in millions

	2012	2011
ASSETS		
Working capital cash and investments	$ 1,210	$ 1,185
Endowment and other cash and investments	3,776	3,809
Accounts and contributions receivable	675	595
Property, plant, and equipment, net	1,728	1,754
Prepaid expenses and other assets	82	78
Total assets	**$ 7,471**	**$ 7,421**
LIABILITIES		
Payables and accrued liabilities	$ 636	$ 627
Deferred revenue	119	126
Interest rate exchange agreements	316	135
Taxable debt for liquidity	250	365
Project and equipment-related debt	1,131	1,078
Total liabilities	**2,452**	**2,331**
NET ASSETS		
Unrestricted net assets controlled by Vanderbilt University	2,560	2,603
Unrestricted net assets related to noncontrolling interests	201	199
Temporarily restricted net assets	1,191	1,262
Permanently restricted net assets	1,067	1,026
Total net assets	**5,019**	**5,090**
Total liabilities and net assets	**$ 7,471**	**$ 7,421**

Total net assets include Vanderbilt's endowment valued at $3,360 million as of June 30, 2012. Net assets associated with capital infrastructure totaled $597 million, which represents the university's property, plant, and equipment, net of accumulated depreciation and capital-related debt. Other net assets, which totaled $1,062 million as of June 30, 2012, include current assets and current liabilities, net of mark-to-market adjustments on interest rate exchange agreements, and net assets related to noncontrolling interests.

Vanderbilt's assets, totaling $7,471 million as of June 30, 2012, reflect a 0.7% increase from the prior year. This increase is attributable primarily to net operating results offset by a slight decline in the endowment.

Total liabilities increased by $121 million to $2,452 million as of June 30, 2012. This increase is attributable largely to an increase in the mark-to-market liability associated with the university's interest rate exchange agreements.

The summary of financial position shown on this page summarizes several asset and liability lines from the consolidated statements of financial position. The summary on this page also segregates the university's cash and investments into (a) working capital, which consists of operating accounts and proceeds from taxable liquidity borrowings, and (b) endowment and other cash and investments. Also, debt is segregated in the summary between taxable debt designated for liquidity enhancement and capital-related debt.

Cash and Liquidity

Vanderbilt's working capital cash and investments, which include highly liquid operating accounts, amounts posted as collateral (primarily related to interest rate exchange agreements), and amounts invested in the long-term investment pool alongside the endowment, totaled $1,210 million as of June 30, 2012. During fiscal 2012, working capital cash and investments increased by $25 million primarily due to strong operating results offset by the growth in receivables and early debt retirements.

Operating assets continue to be invested in a conservative, diversified manner to ensure adequate liquidity under modeled stress scenarios. During the past year Vanderbilt's endowment also provided increased liquidity support, especially monthly liquidity, while still maintaining a long-term investment horizon. As of June 30, 2012, $1,686 million of operating and endowment assets were available within 30 days, including $792 million available on a same-day basis. Based largely on this very strong liquidity position, Vanderbilt holds the highest short-term ratings by the major credit rating agencies.

To provide supplemental liquidity support, Vanderbilt maintains agreements with two banks to provide operating lines of credit with maximum available commitments totaling $300 million. In addition, Vanderbilt carries $200 million of revolving credit facilities with two banks to provide dedicated self-liquidity support for the debt portfolio.

Debt

Vanderbilt's debt portfolio includes fixed-rate debt, variable-rate debt, and commercial paper, along with interest rate exchange agreements that are used for hedging interest rate exposures within the university's debt portfolio.

In accordance with our strategic capital plan, Vanderbilt did not issue incremental debt during fiscal 2012. Scheduled principal payments on long-term debt, early retirements of fixed-rate debt, and elective reductions of commercial paper reduced total outstanding debt by $62 million to a balance of $1,381 million as of June 30, 2012. This amount consisted of $1,131 million of capital project-related debt and $250 million of taxable debt for liquidity support. For operational and management reporting purposes, during fiscal 2012, Vanderbilt designated $115 million of then-outstanding taxable commercial paper to be a component of the university's capital project-financing framework, whereas in the prior year this amount was considered taxable debt for liquidity.

During fiscal 2012, Vanderbilt refinanced $134 million of weekly-remarketed variable-rate debt with floating-rate notes having tender dates in three and five years, which reduced total weekly remarketing risk. Also, to reduce net interest costs, Vanderbilt refinanced $42 million of fixed-rate debt with newly issued fixed-rate debt having a final maturity date in fiscal 2018.

Statements of Activities

Vanderbilt's total operating and nonoperating activity resulted in a $71 million decrease in net assets in fiscal 2012, which follows a $717 million increase in fiscal 2011.

Summary of Statements of Activities
all net asset categories, in millions

	2012	2011
CONSOLIDATED REVENUES		
Tuition and educational fees, net of financial aid	$ 250	$ 244
Government grants and contracts and F&A costs recovery	545	545
Private grants and contracts	55	53
Contributions	83	98
Endowment distributions	148	152
Investment income	19	34
Health care services	2,462	2,294
Room, board, and other auxiliary services, net of financial aid	110	104
Other sources	39	40
Total consolidated revenues	**3,711**	**3,564**
CONSOLIDATED EXPENSES		
Instruction, academic support, and student services	665	632
Research	439	441
Health care services	2,184	2,047
Public service	45	39
Institutional support	42	47
Room, board, and other auxiliary services	132	135
Total consolidated expenses	**3,507**	**3,341**

Summary of Statements of Activities (continued)
all net asset categories, in millions

	2012	2011
OTHER CHANGES IN NET ASSETS		
Changes in appreciation of endowment, net of distributions	(95)	256
(Losses) gains on interest rate exchange agreements	(181)	72
Increase in net assets related to non-controlling interests	2	122
Other nonoperating activity	(1)	44
Total other changes in net assets	**(275)**	**494**
(Decrease) increase in net assets	**$ (71)**	**$ 717**

During fiscal 2012, the decrease in total net assets primarily resulted from strong net operating activity offset by mark-to-market losses on interest rate exchange agreements and an excess of endowment distributions over current year investment return. In comparison, the increase in fiscal 2011 primarily resulted from strong net operating activity, endowed gifts and pledges, net gains in the endowment, and mark-to-market gains on interest rate exchange agreements.

Consolidated revenues and expenses, as presented on this page, include revenues and other support in all net asset categories. Operating activity specific to *unrestricted* net assets is discussed on the following pages. In addition to unrestricted operating activity, consolidated revenues include activity in *temporarily restricted* and *permanently restricted* net assets.

Consolidated Revenues

Consolidated revenues increased $147 million or 4.1% to $3,711 million in fiscal 2012, as compared to $3,564 million in fiscal 2011. This increase was driven primarily by a 7.3% increase in health care services revenue largely due to volume increases in the hospitals and clinics. Vanderbilt's health care services are discussed further in a subsequent section.

Consolidated Expenses

Consolidated expenses increased by 5.0% to $3,507 million in fiscal 2012, as compared to $3,341 million in fiscal 2011. This increase was driven primarily by a 6.7% increase in health care services expenses, and a 5.2% increase in total instruction, academic support, and student services expenses.

Other Changes in Net Assets

Other changes in net assets included changes in appreciation of endowment, net of distributions, totaling negative $95 million in fiscal 2012 and $256 million in fiscal 2011. The fiscal 2012 change in appreciation for the endowment resulted from a 1.3% investment return offset by 4.4% of the endowment utilized for distributions.

In fiscal 2012, Vanderbilt incurred net unrealized losses totaling $181 million on interest rate exchange agreements. These losses are based on mark-to-market valuations of the university's portfolio of interest rate exchange agreements, especially fixed-payer exchange contracts. Adjustments to annual interest expense occur for net cash settlements as Vanderbilt *pays* an average of 3.7% on its fixed-payer contracts and *receives* amounts based on a percentage of 1-month LIBOR rates. The unrealized mark-to-market valuation on these agreements was driven primarily by long-term LIBOR rates. During the past year, the 30-year LIBOR rate decreased to 2.5% as of June 30, 2012—down from 4.1% as of June 30, 2011—which resulted in an increase to the fair value of the liability for the agreements.

Net assets related to noncontrolling interests increased $2 million due to the change in appreciation allocable to noncontrolling interests offset by a slight decrease in net capital contributions. Finally, net other nonoperating activity totaled negative $1 million in fiscal 2012 compared to $44 million in fiscal 2011. Fiscal 2011 activity included $16 million of net gains related to the sale of an investment in the Windsor Health Plan as well as net investment gains related to assets set aside as a reserve for medical self-insurance.

Summary of Changes in Net Assets
in millions

	2012	2011
Revenues and expenses:		
Unrestricted operating revenues	$ 3,665	$ 3,480
Unrestricted operating expenses	(3,507)	(3,341)
Unrestricted operating activity	158	139
Contribution activity in temporarily restricted and permanently restricted net assets	36	55
Investment income and endowment distributions in temporarily restricted and permanently restricted net assets	10	29
Other changes in net assets:		
Change in appreciation of endowment, net of distributions	(95)	256
(Losses) gains on interest rate exchange agreements	(181)	72
Increase in net assets related to noncontrolling interests	2	122
Other nonoperating activity	(1)	44
(Decrease) increase in net assets	**$ (71)**	**$ 717**
Ending balance of net assets	**$ 5,019**	**$ 5,090**

Unrestricted Operating Activity

The change in unrestricted net assets from operating activity is the measure of the university's *operating results*. This unrestricted operating activity totaled $158 million in fiscal 2012 and $139 million in fiscal 2011.

Operating Revenues

Unrestricted operating revenues totaled $3,665 million in fiscal 2012, reflecting a 5.3% increase from the prior year.

Despite increasing budgetary constraints faced by governmental grantors, government grants and contracts revenue, predominantly for research activities, and facilities and administrative (F&A) costs recovery remained stable from fiscal 2011 to 2012. Federal funding from the National Institutes of Health, the Department of Defense, NASA, and other federal agencies comprised 86% and 87% of sponsored research revenues at Vanderbilt in fiscal 2012 and 2011, respectively.

In fiscal 2012, grants and contracts revenue and F&A costs recovery (from both governmental and private sponsors) of $600 million included $511 million related to research; the remainder supported institutional, patient care, and public service initiatives. Vanderbilt also provided $48 million of supplemental institutional funds, resulting in $559 million of resources that were expended for research.

Operating Revenues by Source
unrestricted net assets, in millions

	2012	2011
Tuition and educational fees, net of financial aid	$ 250	$ 244
Government grants and contracts and F&A costs recovery	545	545
Private grants and contracts	55	53
Contributions, including net assets released from restrictions	47	43
Endowment distributions	137	142
Investment income	20	15
Health care services	2,462	2,294
Room, board, and other auxiliary services, net of financial aid	110	104
Other sources	39	40
Total operating revenues	**$ 3,665**	**$ 3,480**

As illustrated below, the majority of the $559 million in total research expenditures for fiscal 2012 was funded by federal government grants and contracts.

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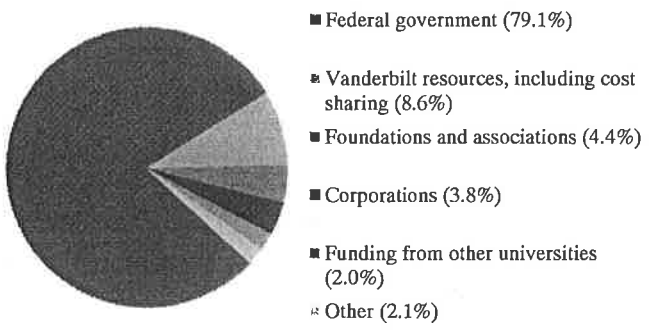
Research Expenditures by Funding Source
fiscal 2012



Although Vanderbilt's research support outlook remains strong, we temper our optimism in light of continued fiscal pressures on governmental funding sources. Sponsored research and project awards, which included multiple-year grants and contracts from government sources, foundations, associations, and corporations, totaled $572 million in fiscal 2012 and $587 million in fiscal 2011 as shown in the table below.

Sponsored Research and Project Awards
in millions

	2012	2011
American Recovery and Reinvestment Act of 2009 (ARRA)	$ 137	$ 125
Other awards	435	462
Total sponsored research and project awards	**$ 572**	**$ 587**

Operating Expenses

Operating expenses totaled $3,507 million in fiscal 2012, reflecting a 5.0% increase from the prior year.

Operating Expenses by Function
unrestricted net assets, in millions

	2012	2011
Instruction, academic support, and student services	$ 665	$ 632
Research	439	441
Health care services	2,184	2,047
Public service	45	39
Institutional support	42	47
Room, board, and other auxiliary services	132	135
Total operating expenses	**$ 3,507**	**$ 3,341**

Expenses for instruction, academic support, and student services increased 5.2% in fiscal 2012. These expenses substantially exceed net tuition revenues, which are noted on the preceding page. Therefore, Vanderbilt, like other major private research universities, relies upon contributions, endowment support, and other alternative sources of revenue—in addition to tuition—to meet its educational mission objectives.

Research expenses as reflected on the consolidated statements of activities decreased 0.5% to $439 million in fiscal 2012 from $441 million in fiscal 2011. In addition to direct costs, research expenses include allocations of overhead and other support costs such as depreciation and interest on indebtedness.

Health care services expenses increased 6.7% to $2,184 million in fiscal 2012 from $2,047 million in fiscal 2011. This increase is attributable largely to an overall increase in patient volumes.

Health Care

Health care is an industry that represents nearly one-fifth of the United States economy and few would dispute that most families and individuals will be impacted significantly as health care continues to face unprecedented challenges. As a prime example, the June 2012 U.S. Supreme Court ruling upholding in large measure the 2010 Patient Protection and Affordable Care Act will continue to put pressure on hospitals and insurers, among others, to accelerate innovation geared to quickly delivering more effective, high-quality care at lower reimbursement rates.

Vanderbilt retains an unwavering commitment to continually striving to provide high quality health care services at reimbursement rates that meet key community needs, including providing substantial charity care for members of the community who otherwise would not be able to secure needed services. More specifically, Vanderbilt's hospitals, clinics, and physician practices are responding to health care reform with innovations in quality of care, patient access, and efficiency of care delivery. Strategies include managing high-cost patient populations with the goal of enhancing patient care processes to reduce costs and improve outcomes, and a focus on initiatives to avoid hospital readmissions, health care acquired infections, and other adverse events. Vanderbilt has implemented significant improvements in clinical information systems resulting in increased leverage of electronic health information. The medical center also is developing affiliations with community providers to improve access to broader patient populations for our students, residents, and researchers, and we are exploring bundled payment models for certain episodes of care.

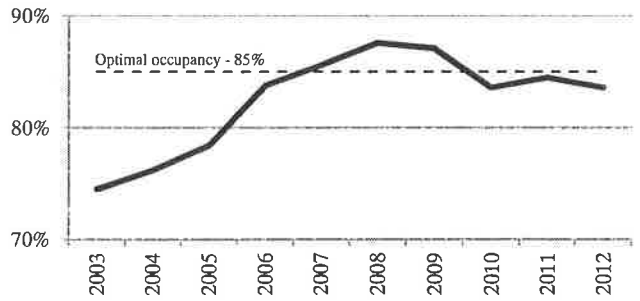
Vanderbilt University Medical Center finished fiscal 2012 in the *U.S. News & World Report* annual ranking of America's Best Hospitals with 11 ranked specialties out of a possible 16 categories. Specialty programs ranking among the top 35 in their respective fields: cancer; cardiology and heart surgery; diabetes and endocrinology; ear, nose, and throat; gastroenterology; gynecology; nephrology; neurology and neurosurgery; orthopedics; pulmonology; and urology. Vanderbilt was among only 3% of facilities analyzed (nearly 4,800) for this year's rankings to be named in at least one specialty. In addition, the Monroe Carell Jr. Children's Hospital at Vanderbilt was included among the nation's leaders in pediatric health care in *U.S. News & World Report* magazine's Best Children's Hospital rankings. The hospital achieved rankings in a maximum 10 out of 10 specialties: cancer, cardiology and heart surgery, diabetes and endocrinology, gastroenterology, neonatology, neph-

rology, neurology and neurosurgery, orthopedics, pulmonology, and urology.

Successful volume growth in recent years led to peaking occupancy rates and capacity constraints in Vanderbilt's hospitals. Vanderbilt's overall hospital occupancy rates were 83.6% in fiscal 2012, an anticipated decrease from 84.5% in fiscal 2011, due to the addition of 69 licensed beds during fiscal 2012.

Vanderbilt completed construction of a 33-bed expansion to the children's hospital in April 2012, and added a total of 36 beds in the adult hospital, inclusive of a new 34-bed floor in the Critical Care Tower, which opened in May 2012. One of two remaining floors in the Critical Care Tower that was originally left in a shelled-out state is currently under construction. Occupancy is anticipated by the second quarter of fiscal 2013. Other renovations in the adult hospital will yield additional beds, resulting in an anticipated 34 new beds during fiscal 2013. The long-term outlook is for continued growth in inpatient services. The bed expansions are necessary to manage occupancy in the 85% range in order to avoid overcrowding and long wait times for patients in the emergency room, recovery rooms, and other procedural staging areas.

Percentage Occupancy
licensed beds



Inpatient hospital surgical operations declined 0.3% in fiscal year 2012 compared to the prior year while surgeries for outpatients increased 12.3%. In the outpatient clinics, ambulatory visits increased 8.8% to total 1,725,901 in fiscal 2012 as Vanderbilt continued its expansion of health care services offered outside the medical center's main campus. Approximately 43% of outpatient visits occurred at off-campus locations. Growth in ambulatory visits also occurred as the result of physician practice expansions in cardiology, neurology, and ophthalmology in nearby Williamson County and Wilson County.

Responding to the strong growth in outpatient services in Williamson County, Vanderbilt purchased 22 acres of unimproved land in that area during fiscal 2011. Vanderbilt currently is in the design stage of a medical office building of approximately 200,000 square feet that would consolidate several existing physician practice locations, as well as provide space for growth.

The average length of stay for patients in Vanderbilt's hospitals remained consistently low at 5.3 days in fiscal 2012 as compared to 5.4 days in fiscal 2011. This decrease predominantly was due to higher growth rates in obstetrics and normal newborn deliveries which have a lower length of stay (2.2 days) than other medical/surgical acute services.

The medical center's overall case mix index (CMI) declined to 1.90 for fiscal 2012 from 1.93 for fiscal 2011, due to higher growth rates in low-CMI services such as obstetric and normal newborn deliveries versus higher-CMI medical/surgical acute care services. Excluding obstetrics and normal newborn deliveries, the case mix index was 2.18 in fiscal 2012 comparing closely to 2.19 in fiscal 2011. While having patient acuity levels that are among the highest quartile of teaching hospitals, Vanderbilt's mortality index measure is one of the best in the nation. This outcome is reflective of the high quality of care at our hospitals, with a continued focus on evidence-based medicine and clinical improvement. Besides high quality care continuing to be a key factor in reduced actuarially determined medical malpractice expenses, the medical center had other one-time favorable adjustments to fiscal 2012 income such as settlements from government agencies. Collectively, these items totaled approximately $38 million.

The following table shows payor mix percentages based on gross patient revenues for Vanderbilt's hospitals and clinics in fiscal 2012 and fiscal 2007 (five years prior). Vanderbilt's medical center has experienced a decline in the percentage of TennCare/Medicaid patients, primarily because TennCare organizations have developed broader physician and hospital provider networks that allow low-acuity health care services to be provided in the local communities. Further, due to high quality and favorable patient satisfaction scores, the community preference for Vanderbilt's hospitals and clinics continues to increase, resulting in modest market share growth in the managed care payor group over the past five years.

Payor Mix
Vanderbilt hospitals and clinics (% of gross patient revenues)

	2012	2007
Managed care	38.7%	38.3%
Medicare	26.1	23.1
TennCare/Medicaid	18.2	19.6
Commercial indemnity	8.4	9.7
Uninsured (self-pay) and other	8.6	9.3
Total payor mix	**100.0%**	**100.0%**

The university's medical center maintains a charity care policy which sets forth the criteria for health care services that are provided without expectation of payment, or at a reduced payment rate to patients who meet certain income criteria based on federal poverty limit guidelines. These services are accounted for as charity care and are not reported as revenue.

Of the total uncompensated care provided by the medical center (comprising charity care and bad debt reflected as deductions from gross revenue), 78% and 75% of the total in fiscal 2012 and 2011, respectively, was charity care. Charity care services represent 5.7% and 5.4%, respectively, of total patient services revenue in fiscal 2012 and 2011.

In addition to uncompensated care, the medical center provides a number of other services to benefit the economically disadvantaged for which little or no payment is received. These services include public health education and training for new health professionals and services to patients with special needs.

Finally, in addition to charity care assistance and community benefits previously noted, Vanderbilt provides other substantial community benefits in the form of clinical and laboratory research support.

This activity is primarily conducted by the schools of medicine and nursing and includes direct and indirect costs of research funded by other tax-exempt organizations, government entities, and internal funding sources.

A summary of costs for the preceding community benefit activities, which are regularly reported in Vanderbilt's Form 990 filing (Return of Organization Exempt from Income Taxes), is provided in the following table.

Charity Care
in millions

	2012	2011
Charity care and community benefits		
Unreimbursed cost of charity care	$ 120,069	$ 104,220
Resident and Allied Health education	86,055	74,076
Unreimbursed cost of TennCare/ Medicaid	47,213	47,807
Other community health programs	5,386	5,283
Behavioral health hospital services	806	2,607
Clinical and laboratory research support	494,807	493,244
Total costs of charity care and community benefits	754,336	727,237
Other unrecovered costs using IRS Form 990 Schedule H guidelines but not includable as community benefits		
Unreimbursed cost of Medicare	54,662	52,788
Cost of bad debts	34,248	33,728
Unreimbursed cost of TRICARE	8,701	9,616
Total other unrecovered costs	97,611	96,132
Total cost of charity care, community benefits, and other unrecovered costs	**$ 851,947**	**$ 823,369**

Endowment

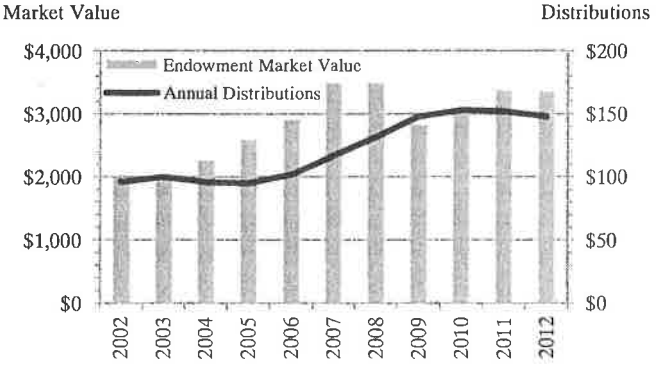
For fiscal 2012, Vanderbilt's endowment portfolio had an investment return of 1.3%. Endowment distributions totaling $148 million in fiscal 2012 were used to support the university's education, research, and public service missions. The endowment ended fiscal 2012 with a $3,360 million total market value. The overall change in absolute value not only reflects investment return and the distribution of endowment funds to support university operations, but also the net impact of new endowment gifts and additions to institutional endowments (quasi-endowments). During fiscal 2012, the university added $88 million to the endowment portfolio through new gifts and additions to institutional endowments (quasi-endowments).

Fiscal 2012 proved to be a challenging year, as investor sentiment and markets shifted from negative to positive then back again to negative. This "Risk On/Risk Off" was the common theme throughout the year as the *Euro Crisis* weighed heavily on the markets. Global equity markets finished the twelve-month period ending June 30, down 6.5%, after rallying back from a 17% decline during the first three months of the fiscal year. Fortunately, Vanderbilt's fixed income, private markets, and natural resources posted positive returns, offsetting the equity allocation's negative return.

At the strategy level, long-term treasuries, technology-based venture funds, and private equity were top performers and the most favorable contributors to the endowment's fiscal 2012 performance. An under-allocation to global equities, and an over-allocation to private market investments, including private equity and venture capital investments, also aided returns on both an absolute and relative basis. While disappointed with the fiscal year's modest absolute return we are pleased to have posted a positive return during what has proven to be a challenging investing environment.

Financial markets continue to show signs of vulnerability due to the pending "fiscal cliff" facing the United States, continued high unemployment, sovereign debt risk, inflation in developing markets, and global political instability. Fortunately, Vanderbilt has implemented a number of strategic initiatives to enhance the university's ability to navigate through what many consider a protracted low-return and high-volatility environment. These measures include enhancing overall liquidity, solidifying strategic relationships with premier managers, expanding geographical breadth, and improving transparency and systems.

Endowment Market Value and Annual Distributions
in millions



Endowment Asset Allocation
June 2012 (% of portfolio)

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	Actual	Target
Global equities	31.4%	35.0%
Absolute return	20.0	25.0
Fixed income	5.2	10.0
Cash and cash equivalents	0.2	-
Total marketable	**56.8**	**70.0**
Private markets	27.7	15.0
Real estate	7.9	7.5
Natural resources	7.5	7.5
Other	0.1	-
Total nonmarketable	**43.2**	**30.0**
Total endowment	**100.0%**	**100.0%**

Conclusion

Vanderbilt ended fiscal 2012 in a strong financial position. The university continues to focus on strategic prioritization by utilizing financial resources wisely to further the university's mission and goals. Although the economic climate is marked with uncertainty with anticipated declines in government funding, health care reform, and general operating and capital demands, we remain confident that the strong financial footing that is currently in place at Vanderbilt coupled with prudent management decisions will continue to pave the way for a bright future.

Vanderbilt is positioned to take on new and complex projects that are ambitious, but will serve to take the university to yet a higher level of excellence. Capital investments, such as the next phase of College Halls at Vanderbilt, as well as investments in faculty and research are on the forefront of plans for both the present and the foreseeable future.

As reflected in the audited financial statements, the financial ratios, and as noted in this financial overview, Vanderbilt's fiscal standing remains strong. We are committed to careful stewardship of Vanderbilt's resources so that we can carry out our mission and further enhance our position as one of the world's premier higher education institutions.

Financial Ratios

Expendable Net Assets to Debt

Expendable Net Assets / Project Debt and Lease Commitments

2008	2009	2010	2011	2012
2.7x	1.9x	2.1x	2.3x	2.4x

Expendable net assets to debt measures the university's leverage. Debt used for calculating this ratio consists of all project-related debt, the net present value of lease commitments, and debt guarantees.

Vanderbilt's expendable net assets to debt increased slightly in fiscal 2012 as the result of positive operating results and a decline in outstanding debt, tempered by a net decrease in endowment market value and increased interest rate exchange agreements portfolio liability. The improvement in fiscal 2011 was the result of positive endowment returns and operating results. Vanderbilt aims to maintain expendable net assets to debt of at least 2.0.

Debt Service Coverage Ratio

Unrestricted Operating Results before Interest and Depreciation / Normalized Annual Debt Service

2008	2009	2010	2011	2012
3.4x	3.2x	3.6x	4.0x	4.1x

The *debt service coverage ratio* measures the university's ability to pay annual debt service obligations from current year operating activities. In this context, annual debt service is normalized to calculate long-term (25 years), level principal and interest payments that would be required based on the portfolio's then-prevailing weighted average interest rates inclusive of the effects of interest rate exchange agreements. The scope for this ratio is all outstanding debt, except for taxable commercial paper used for short-term liquidity support prior to fiscal 2012.

Vanderbilt's debt service coverage ratio increased in fiscal 2012 and 2011 primarily as the result of strong net operating results. The debt portfolio's effective interest rate, which includes the impact of interest rate exchange agreements, declined in fiscal 2012 and 2011 – a favorable impact on normalized annual debt service. Vanderbilt aims to maintain a debt service coverage ratio of at least 2.0.

Debt Service Burden[1]

Normalized Annual Debt Service / Unrestricted Operating Expenses

2008	2009	2010	2011	2012
2.5%	2.7%	3.3%	2.9%	2.8%

The *debt service burden* measures the percent of the annual operating budget devoted to servicing outstanding debt.

Vanderbilt's debt service burden decreased in fiscal 2012 and 2011 primarily due to stable normalized annual debt service coupled with an increase in operating expenses. Vanderbilt aims to maintain a debt service burden below 5.0%.

Operating Cash Flow Margin[1]

Unrestricted Operating Results before Interest and Depreciation / Unrestricted Operating Revenues

2008	2009	2010	2011	2012
8.2%	8.7%	11.4%	11.1%	10.9%

The *operating cash flow margin* measures the cash flow generated from each dollar of operating revenue. The resulting net cash flows may occur in the current or future years depending on changes in receivables and payables.

In fiscal 2012, Vanderbilt's unrestricted operating results before interest and depreciation increased 2.8% to $398 million from $387 million in fiscal 2011. Fiscal 2012 unrestricted operating revenues, at $3,665 million, represent a 5.3% increase from $3,480 million in fiscal 2011.

Capital Intensiveness Ratio[1]

Acquisitions of Property, Plant, and Equipment / Unrestricted Operating Revenues

2008	2009	2010	2011	2012
9.3%	8.5%	5.2%	3.6%	3.9%

The *capital intensiveness ratio* measures the university's annual investments in property, plant, and equipment as a percentage of the university's annual operating revenues.

Vanderbilt's capital intensiveness ratio increased in fiscal 2012 as spending on major capital projects increased in accordance with the university's capital plan. During fiscal 2012, major capital projects included the bed-expansion of the Monroe Carell Jr. Children's Hospital at Vanderbilt, the Critical Care Tower buildout, College Halls at Kissam, and the Blakemore House purchase and renovation.

Average Age of Plant

Accumulated Depreciation / Depreciation Expense

2008	2009	2010	2011	2012
9.4 yrs	9.5 yrs	10.0 yrs	10.2 yrs	11.2 yrs

The *average age of plant* metric provides a sense of the age of the university's facilities. A low average age of plant indicates that an institution has made significant recent investments in its plant. Generally, a strong level for this ratio is deemed to be 12 years or less for research institutions and 14 years or less for predominantly liberal arts institutions.

[1] Due to the adoption of Accounting Standards Update 2011-7 (ASU 2011-7), *Health Care Entities: Presentation and Disclosure of Net Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts,* affected financial ratios for fiscal 2008 through fiscal 2011 have been recalculated to provide comparability to fiscal 2012 ratios.

VANDERBILT UNIVERSITY

Consolidated Financial Statements

pwc

Report of Independent Auditors

Board of Trust
Vanderbilt University:

In our opinion, the accompanying consolidated statements of financial position and the related statements of activities and cash flows present fairly, in all material respects, the financial position of Vanderbilt University at June 30, 2012 and June 30, 2011, and the changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America. These financial statements are the responsibility of Vanderbilt University's management. Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits of these statements in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As discussed in Note 2, Vanderbilt adopted ASU 2011-07, "Health Care Entities: Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities" effective July 1, 2011.

PricewaterhouseCoopers LLP

October 19, 2012

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T: (646) 471 3000, F: (813) 236 6000, www.pwc.com/us

Vanderbilt University
Consolidated Statements of Financial Position

As of June 30, 2012 and 2011 (in thousands)

	2012	2011
ASSETS		
Cash and cash equivalents	$ 912,419	$ 1,129,804
Accounts receivable, net	518,566	436,687
Prepaid expenses and other assets	82,167	78,756
Contributions receivable, net	72,334	78,572
Student loans and other notes receivable, net	45,409	40,207
Investments	3,872,014	3,664,182
Investments allocable to noncontrolling interests	201,386	199,249
Property, plant, and equipment, net	1,727,611	1,754,524
Interests in trusts held by others	39,257	39,362
Total assets	**$ 7,471,163**	**$ 7,421,343**
LIABILITIES		
Accounts payable and accrued liabilities	$ 228,422	$ 236,428
Accrued compensation and withholdings	245,859	225,360
Deferred revenue	118,826	125,458
Actuarial liability for self-insurance	105,543	111,348
Actuarial liability for split-interest agreements	34,171	32,775
Government advances for student loans	22,113	21,036
Commercial paper	264,075	264,862
Long-term debt and capital leases	1,117,029	1,178,531
Fair value of interest rate exchange agreements, net	315,577	135,026
Total liabilities	**2,451,615**	**2,330,824**
NET ASSETS		
Unrestricted net assets controlled by Vanderbilt	2,559,802	2,603,397
Unrestricted net assets related to noncontrolling interests	201,386	199,249
Total unrestricted net assets	2,761,188	2,802,646
Temporarily restricted net assets	1,191,216	1,262,271
Permanently restricted net assets	1,067,144	1,025,602
Total net assets	**5,019,548**	**5,090,519**
Total liabilities and net assets	**$ 7,471,163**	**$ 7,421,343**

The accompanying notes are an integral part of the consolidated financial statements.

Vanderbilt University
Consolidated Statement of Activities

Year Ended June 30, 2012 (in thousands)

	2012			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
REVENUES AND OTHER SUPPORT				
Tuition and educational fees, net	$ 250,137	$ -	$ -	$ 250,137
Grants and contracts:				
Government sponsors	397,555	-	-	397,555
Private sponsors	54,768	-	-	54,768
Facilities and administrative costs recovery	147,806	-	-	147,806
Total grants and contracts	600,129	-	-	600,129
Contributions	25,861	28,430	28,580	82,871
Endowment distributions	136,883	8,565	2,447	147,895
Investment income (loss)	19,831	276	(969)	19,138
Health care services	2,461,830	-	-	2,461,830
Room, board, and other auxiliary services, net	109,733	-	-	109,733
Other sources	39,068	-	-	39,068
Net assets released from restrictions	21,459	(21,459)	-	-
Total revenues and other support	**3,664,931**	**15,812**	**30,058**	**3,710,801**
EXPENSES				
Instruction	480,296	-	-	480,296
Research	439,395	-	-	439,395
Health care services	2,184,054	-	-	2,184,054
Public service	44,889	-	-	44,889
Academic support	148,871	-	-	148,871
Student services	35,586	-	-	35,586
Institutional support	41,851	-	-	41,851
Room, board, and other auxiliary services	132,458	-	-	132,458
Total expenses	**3,507,400**	**-**	**-**	**3,507,400**
Change in unrestricted net assets from operating activity	**157,531**			
OTHER CHANGES IN NET ASSETS				
Change in appreciation of endowment, net of distributions	(31,447)	(62,982)	-	(94,429)
Change in appreciation of self-insurance assets	876	-	-	876
Change in appreciation of other investments	(2,476)	-	-	(2,476)
Change in appreciation of interest rate exchange agreements	(180,551)	-	-	(180,551)
Contributions for plant	1,813	-	-	1,813
Net assets released from restrictions for plant	24,210	(24,210)	-	-
Donor designation changes	(11,809)	325	11,484	-
Other	(1,742)	-	-	(1,742)
Total other changes in net assets	**(201,126)**	**(86,867)**	**11,484**	**(276,509)**
(Decrease) increase in net assets controlled by Vanderbilt	**(43,595)**	**(71,055)**	**41,542**	**(73,108)**
Increase in net assets related to noncontrolling interests	**2,137**	**-**	**-**	**2,137**
Total (decrease) increase in net assets	**$ (41,458)**	**$ (71,055)**	**$ 41,542**	**$ (70,971)**
Net assets, June 30, 2011	**$ 2,802,646**	**$ 1,262,271**	**$ 1,025,602**	**$ 5,090,519**
Net assets, June 30, 2012	**$ 2,761,188**	**$ 1,191,216**	**$ 1,067,144**	**$ 5,019,548**

The accompanying notes are an integral part of the consolidated financial statements.

Vanderbilt University
Consolidated Statement of Activities

Year Ended June 30, 2011 (in thousands)

	2011			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
REVENUES AND OTHER SUPPORT				
Tuition and educational fees, net	$ 243,859	$ -	$ -	$ 243,859
Grants and contracts:				
Government sponsors	399,440	-	-	399,440
Private sponsors	53,494	-	-	53,494
Facilities and administrative costs recovery	145,295	-	-	145,295
Total grants and contracts	598,229	-	-	598,229
Contributions	23,564	22,621	51,314	97,499
Endowment distributions	142,252	7,450	2,556	152,258
Investment income	14,666	13,583	6,062	34,311
Health care services	2,293,962	-	-	2,293,962
Room, board, and other auxiliary services, net	103,769	-	-	103,769
Other sources	40,351	-	-	40,351
Net assets released from restrictions	19,160	(19,160)	-	-
Total revenues and other support	**3,479,812**	**24,494**	**59,932**	**3,564,238**
EXPENSES				
Instruction	464,313	-	-	464,313
Research	441,064	-	-	441,064
Health care services	2,047,489	-	-	2,047,489
Public service	39,262	-	-	39,262
Academic support	133,076	-	-	133,076
Student services	34,919	-	-	34,919
Institutional support	46,879	-	-	46,879
Room, board, and other auxiliary services	133,879	-	-	133,879
Total expenses	**3,340,881**	**-**	**-**	**3,340,881**
Change in unrestricted net assets from operating activity	**138,931**			
OTHER CHANGES IN NET ASSETS				
Change in appreciation of endowment, net of distributions	102,258	153,510	-	255,768
Change in appreciation of self-insurance assets	11,299	-	-	11,299
Change in appreciation of other investments	13,767	-	-	13,767
Change in appreciation of interest rate exchange agreements	72,070	-	-	72,070
Contributions for plant	3,430	560	-	3,990
Net assets released from restrictions for plant	16,689	(16,689)	-	-
Donor designation changes	(11,859)	(7,628)	19,487	-
Other	15,477	-	-	15,477
Total other changes in net assets	**223,131**	**129,753**	**19,487**	**372,371**
Increase in net assets controlled by Vanderbilt	**362,062**	**154,247**	**79,419**	**595,728**
Increase in net assets related to noncontrolling interests	**121,554**	**-**	**-**	**121,554**
Total increase in net assets	**$ 483,616**	**$ 154,247**	**$ 79,419**	**$ 717,282**
Net assets, June 30, 2010	**$ 2,319,030**	**$ 1,108,024**	**$ 946,183**	**$ 4,373,237**
Net assets, June 30, 2011	**$ 2,802,646**	**$ 1,262,271**	**$ 1,025,602**	**$ 5,090,519**

The accompanying notes are an integral part of the consolidated financial statements.

Vanderbilt University
Consolidated Statements of Cash Flows

Years Ended June 30, 2012 and 2011 (in thousands)

	2012	2011
CASH FLOWS FROM OPERATING ACTIVITIES		
(Decrease) increase in total net assets	**$ (70,971)**	**$ 717,282**
Adjustments to reconcile change in total net assets to net cash provided by operating activities:		
Increase in net assets related to noncontrolling interests	(2,137)	(121,554)
Net realized gains on investments	(56,783)	(56,526)
Net decrease (increase) in unrealized appreciation on investments	39,985	(305,940)
Contributions for plant and endowment	(59,069)	(78,032)
Contributions of securities other than for plant and endowment	(10,095)	(11,062)
Depreciation and amortization	172,718	173,195
Amortization and reclassification of bond discounts and premiums	1,430	(2,355)
Payments to terminate interest rate exchange agreements	-	23,680
Net decrease (increase) in fair value of interest rate exchange agreements	180,551	(97,289)
Net decrease in fair value of option to execute interest rate exchange agreement	-	1,539
(Increase) decrease in:		
Accounts receivable, net of accrued investment income	(81,640)	(32,280)
Prepaid expenses and other assets	(3,411)	11,479
Contributions receivable	6,238	(1,533)
Interests in trusts held by others	105	(2,969)
Increase (decrease) in:		
Accounts payable and accrued liabilities, net of nonoperating items	(14,126)	(15,531)
Accrued compensation and withholdings	20,499	311
Deferred revenue	(6,632)	808
Actuarial liability for self-insurance	(5,805)	8,590
Actuarial liability for split-interest agreements	1,396	1,311
Net cash provided by operating activities	**112,253**	**213,124**
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of investments	(2,412,099)	(2,416,030)
Proceeds from sales of investments	2,231,160	2,499,503
Purchases of investments allocable to noncontrolling interests	(38,707)	(50,780)
Proceeds from sales of investments allocable to noncontrolling interests	40,815	47,179
(Increase) decrease in accrued investment income	(239)	1,307
Acquisitions of property, plant, and equipment	(143,089)	(124,411)
Proceeds from disposals of property, plant, and equipment	3,404	835
Student loans and other notes receivable disbursed	(10,090)	(3,091)
Principal collected on student loans and other notes receivable	4,888	4,524
Net cash used in investing activities	**(323,957)**	**(40,964)**
CASH FLOWS FROM FINANCING ACTIVITIES		
Contributions for plant and endowment	59,069	78,032
Increase in government advances for student loans	1,077	2,168
Proceeds from debt issuances	180,231	474,946
Payments to retire or defease debt	(243,950)	(536,580)
Payments to terminate interest rate exchange agreements	-	(23,680)
Proceeds from noncontrolling interests in investment partnerships	38,707	50,780
Payments to noncontrolling interests in investment partnerships	(40,815)	(47,179)
Net cash used in financing activities	**(5,681)**	**(1,513)**
Net (decrease) increase in cash and cash equivalents	**$ (217,385)**	**$ 170,647**
Cash and cash equivalents at beginning of year	**$ 1,129,804**	**$ 959,157**
Cash and cash equivalents at end of year	**$ 912,419**	**$ 1,129,804**

The accompanying notes are an integral part of the consolidated financial statements.

Vanderbilt University
Notes to the Consolidated Financial Statements

1. Organization

The Vanderbilt University (Vanderbilt) is a private, coeducational, not-for-profit, nonsectarian institution located in Nashville, Tennessee. Founded in 1873, Vanderbilt owns and operates educational, research, and health care facilities as part of its mission to be a leading center for informed and creative teaching, scholarly research, and public service. Vanderbilt provides educational services to approximately 6,800 undergraduate and 6,000 graduate and professional students enrolled in its 10 schools and colleges.

These consolidated financial statements include the accounts of all entities in which Vanderbilt has a significant financial interest and over which Vanderbilt has control. The patient care enterprise includes Vanderbilt University Hospitals and Clinics; Vanderbilt Medical Group, a physician practice program; and Vanderbilt Health Services, Inc., which includes wholly owned and joint ventured businesses primarily comprised of radiation oncology centers, imaging services, outpatient surgery centers, a home health care agency, and a home infusion and respiratory service.

All significant intercompany accounts and transactions have been eliminated in consolidation.

2. Summary of Significant Accounting Policies

Basis of Presentation
The consolidated financial statements of Vanderbilt have been prepared on the accrual basis in accordance with U.S. generally accepted accounting principles. Based on the existence or absence of donor-imposed restrictions, Vanderbilt classifies resources into three categories: unrestricted, temporarily restricted, and permanently restricted net assets.

Unrestricted net assets are free of donor-imposed restrictions. All revenues, gains, and losses that are not temporarily or permanently restricted by donors are included in this classification. All expenditures are reported in the unrestricted class of net assets, since the use of restricted contributions in accordance with donors' stipulations results in the release of the restriction.

Temporarily restricted net assets are limited as to use by donor-imposed stipulations that expire with the passage of time or that can be satisfied by action of Vanderbilt. These net assets may include unconditional pledges, split-interest agreements, interests in trusts held by others, and accumulated appreciation on donor-restricted endowments which have not yet been appropriated by the Board of Trust for distribution.

Permanently restricted net assets are amounts required by donors to be held in perpetuity. These net assets may include unconditional pledges, donor-restricted endowments (at historical value), split-interest agreements, and interests in trusts held by others. Generally, the donors of these assets permit Vanderbilt to use a portion of the income earned on related investments for specific purposes.

Expirations of temporary restrictions on net assets, i.e., the passage of time along with the concomitant annual Board of Trust approval of the endowment spending rate, and/or fulfilling donor-imposed stipulations, are reported as net assets released from restrictions between the applicable classes of net assets in the consolidated statements of activities.

Fair Value Measurements
Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 820, *Fair Value Measurements and Disclosure* (ASC 820) defines fair value, requires expanded disclosures about fair value measurements, and establishes a three-level hierarchy for fair value measurements based on the observable inputs to the valuation of an asset or liability at the measurement date. Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC 820 prioritizes the inputs to the valuation techniques used to measure fair value by giving the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to measurements involving significant unobservable inputs (Level 3 measurements).

Furthermore, ASC 820 considers certain investment funds that do not have readily determinable fair values including private investments, hedge funds, real estate, and other funds. ASC 820 allows for using net asset value per share or its equivalent in estimating the fair value of interests in investment companies for which a readily determinable fair value is not available.

Cash and Cash Equivalents
Cash and cash equivalents are liquid assets with minimal interest rate risk and maturities of three months or less when purchased. Such assets, reported at fair value, primarily consist of depository account balances, money market funds, and short-term U.S. Treasury securities.

Prepaid Expenses and Other Assets
Prepaid expenses and other assets primarily represent inventories, prepaid expenses, and other segregated investment-related assets managed by third parties related to a legacy deferred compensation program that are earmarked to ultimately settle certain liabilities. This latter group of assets, reported at fair value, is excluded from the investments category since Vanderbilt will not directly benefit from the investment return.

Investments
Investments are reported at fair value using the three-level hierarchy established under ASC 820. Fair values for certain alternative investments, mainly investments in limited partnerships where a ready market for the investments does not exist, are based primarily on estimates reported by fund managers. The estimated values are reviewed and evaluated by Vanderbilt.

Vanderbilt has exposure to a number of risks including liquidity, interest rate, counterparty, basis, tax, regulatory, market, and credit risks for both marketable and nonmarketable securities. Due to the level of risk exposure, it is possible that near-term valuation changes for investment securities may occur to an extent that could materially affect the amounts reported in Vanderbilt's financial statements.

Vanderbilt sometimes uses derivatives to manage investment market risks and exposure. Derivatives, which consist of both internally managed transactions and those entered into through external investment managers, are reported at fair value. The most common instruments utilized are futures contracts and hedges against currency translation risk for investments denominated in other than U.S. dollars. For internally managed transactions, Vanderbilt utilizes futures contracts with durations of less than three months.

Purchases and sales of securities are recorded on the trade dates, and realized gains and losses are determined on the basis of the average historical cost of the securities sold. Net receivables and payables arising from unsettled trades are reported as a component of investments.

All endowment investments are managed as an investment pool, unless donor-restricted endowment gift agreements require that they be held separately.

Investments Allocable to Noncontrolling Interests and Net Assets Related to Noncontrolling Interests
For entities in which other organizations are minority equity participants to Vanderbilt's controlling interest, the respective assets are reported separately on the consolidated statements of financial position at fair value as investments allocable to noncontrolling interests.

The balance representing such organizations' minority or noncontrolling interests is recorded based on contractual provisions, which represent an estimate of a settlement value assuming the entity was liquidated in an orderly fashion as of the report date.

Split-Interest Agreements and Interests in Trusts Held by Others
Vanderbilt's split-interest agreements with donors consist primarily of irrevocable charitable remainder trusts, charitable gift annuities, and life income funds for which Vanderbilt serves as trustee. Assets held in these trusts are included in investments at fair value. Contribution revenue is recognized at the dates the trusts are established, net of the liabilities for the present value of the estimated future payments to be made to the donors and/or other beneficiaries. Annually, Vanderbilt records the change in fair value of split-interest agreements based on the assets that are associated with each trust and recalculates the liability for the present value of the estimated future payments to be made to the donors and/or other beneficiaries.

Vanderbilt is also the beneficiary of certain trusts held and administered by others. Vanderbilt's share of these trust assets is recorded at fair value as interests in trusts held by others with any resulting gains or losses reported as investment income.

Property, Plant, and Equipment
Purchased property, plant, and equipment are recorded at cost, including, where appropriate, capitalized interest on construction financing net of income earned on unspent proceeds. Donated assets are recorded at fair value at the date of donation. Repairs and maintenance costs are expensed as incurred. Additions to the library collection are expensed at the time of purchase.

Depreciation is calculated using the straight-line method to allocate the cost of various classes of assets over their estimated useful lives. Property, plant, and equipment are removed from the accounting records at the time of disposal.

Conditional asset retirement obligations related to legal requirements to perform certain future activities associated with the retirement, disposal, or abandonment of assets are accrued utilizing site-specific surveys to estimate the net present value for applicable future costs, e.g., asbestos abatement or removal.

Vanderbilt reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. An impairment charge is recognized when the fair value of the asset or group of assets is less than the carrying value.

Debt Portfolio Financial Instruments
Long-term debt and capital leases are reported at carrying value. The carrying value of Vanderbilt's debt is the par amount adjusted for the net unamortized amount of bond premiums and discounts. Vanderbilt employs derivatives, primarily interest rate exchange agreements, to help manage interest rate risks associated with variable-rate debt. Derivative financial instruments are reported at fair value with any resulting gain or loss recognized as a nonoperating item in the consolidated statements of activities. In addition to the credit risk of the counterparty owing a balance, the fair value of interest rate exchange agreements is based on the present value sum of future net cash settlements that reflect market yields as of the measurement date. Periodic net cash settlement amounts with counterparties are accounted for as adjustments to interest expense on the related debt.

Parties to interest rate exchange agreements are subject to risk for changes in interest rates as well as risk of credit loss in the event of nonperformance by the counterparty. Vanderbilt deals only with high-quality counterparties that meet rating criteria for financial stability and credit worthiness. Additionally, the agreements require the posting of collateral when amounts subject to credit risk under the contracts exceed specified levels.

Revenue Recognition
Vanderbilt's revenue recognition policies are:

Tuition and educational fees, net—Student tuition and educational fees are recorded as revenues during the year the related academic services are rendered. Student tuition and educational fees received in advance of services to be rendered are recorded as deferred revenue. Financial aid provided by Vanderbilt for tuition and educational fees is reflected as a reduction of tuition and educational fees. Financial aid does not include payments made to students for services provided to Vanderbilt.

Grants and contracts, government sponsors—Revenues from government sponsored grants and contracts are recognized when allowable expenditures are incurred under such agreements.

Grants and contracts, private sponsors—Revenues from private sponsored grants and contracts are recognized when allowable expenditures are incurred under such agreements.

Facilities and administrative (F&A) costs recovery—F&A costs recovery is recognized as revenue and represents reimbursement, primarily from the federal government, of F&A costs on sponsored activities. Vanderbilt's federal F&A costs recovery rate for on-campus research was 56.0% in fiscal 2012 and 55.0% in fiscal

2011. Vanderbilt's federal F&A costs recovery rate for off-campus research was 28.5% in both fiscal 2012 and 2011.

Health care services—Health care services revenue is reported at established rates, net of contractual adjustments, charity assistance services, and provision for bad debt. Third party contractual revenue adjustments under governmental reimbursement programs are accrued on an estimated basis in the period the related services are rendered. The estimated amounts for Medicare are adjusted as final settlements are determined by Vanderbilt's Medicare Administrative Contractor (MAC).

Vanderbilt implemented the provisions of Accounting Standards Update (ASU) 2011-07, *Health Care Entities: Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* (ASU 2011-07) which specifies that bad debt related to patient service revenue is to be reported as a component of net patient service revenue (contra revenue) for fiscal years beginning after December 15, 2011. Vanderbilt elected to early adopt ASU 2011-07 for fiscal 2012. Accordingly, certain amounts in fiscal 2011 have been reclassified to conform to the fiscal 2012 presentation.

Contributions

Unconditional promises to give (pledges) are recognized as contribution revenue when the donor's commitment is received. Pledges with payments due to Vanderbilt in future periods are recorded as increases in temporarily restricted or permanently restricted net assets at the estimated present value of future cash flows, net of an allowance for estimated uncollectible promises. Allowance is made for uncollectible contributions receivable based upon Vanderbilt's analysis of past collection experience and other judgmental factors.

Contributions with donor-imposed restrictions are recorded as unrestricted revenue if those restrictions are met in the same reporting period. Otherwise, contributions with donor-imposed restrictions are recorded as increases in temporarily restricted or permanently restricted net assets, depending on the nature of the restriction.

Contributions recorded as temporarily restricted net assets are released from restrictions and recognized as unrestricted net assets after any donor stipulations are met. Contributions for plant facilities are released from restrictions and recognized as a nonoperating item only after resources are expended for the applicable plant facilities.

Contributions receivable of pledged securities are stated at the fair value of the underlying securities. Net changes on shares pledged in prior years due to fair value changes for the underlying securities are reported separately as nonoperating gains or losses on contributions receivable in the consolidated statements of activities.

In contrast to unconditional promises as described above, conditional promises (primarily bequest intentions) are not recorded until donor contingencies are substantially met.

Operating Results

Operating results (change in unrestricted net assets from operating activity) in the consolidated statements of activities reflect all transactions that change unrestricted net assets, except for nonoperating activity related to endowment and other investments, changes in the fair value of derivative financial instruments, contributions for plant facilities, and certain other nonrecurring items.

Endowment distributions reported as operating revenue consist of endowment return (regardless of when such income arose) distributed to support current operational needs. Vanderbilt's Board of Trust approves the amount to be distributed from the endowment pool on an annual basis, determined by applying a spending rate to an average of the previous three calendar year-end market values. The primary objective of the endowment distribution methodology is to reduce the impact of capital market fluctuations on operational programs.

Operating investment income consists of dividends, interest, and gains and losses on unrestricted, nonendowed investments directly related to core operating activities. Such income includes investment returns on Vanderbilt's working capital assets. For working capital assets invested in long-term pooled investments managed in conjunction with endowment funds, the amount resulting from pre-established distributions from pooled investments is deemed operating investment income; the difference between total returns for these pooled investments and the aforementioned pre-established distributions is reported as nonoperating activity. Operating investment income also excludes investment returns on segregated gift funds and funds set aside for nonoperating purposes such as segregated assets for self-insurance relative to malpractice and professional liability and assets on deposit with trustees.

Management and administrative support costs attributable to divisions that primarily provide health care or auxiliary services are allocated based upon institutional budgets. Thus, institutional support expense separately reported in the consolidated statements of activities relates to Vanderbilt's other primary programs such as instruction, research, and public service.

Costs related to the operation and maintenance of physical plant, including depreciation of plant assets, are allocated to operating programs and supporting activities based upon facility usage. Additionally, interest expense is allocated to the activities that have benefited most directly from the debt proceeds.

Income Taxes

Vanderbilt is a tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code (the Code), and generally is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. Vanderbilt is, however, subject to federal and state income tax on unrelated business income, and provision for such taxes is included in the accompanying consolidated financial statements.

Use of Estimates

The preparation of financial statements requires the use of estimates and assumptions that affect the reported amounts of assets, liabilities, revenues, and expenses during the reporting period as well as the disclosure of contingent assets and liabilities. Actual results ultimately could differ from management's estimates.

Subsequent Events

Vanderbilt evaluated events subsequent to June 30, 2012, and through the date on which the consolidated financial statements were issued, October 19, 2012. No material subsequent events were identified for recognition or disclosure.

Redesignations

When donors amend or clarify intent for applicable contributions reported in a previous fiscal year, revisions are separately reflected as donor designation changes within the consolidated statements of activities.

Reclassifications

Certain reclassifications have been made to prior year amounts to conform to the current year presentation.

3. Accounts Receivable

Accounts receivable as of June 30 were as follows *(in thousands)*:

	2012	2011
Patient care	$ 529,501	$ 448,013
Students, grants, and other	103,861	102,876
Accrued investment income	2,010	1,771
Accounts receivable, gross	635,372	552,660
Less: Allowance for bad debts	116,806	115,973
Accounts receivable, net	**$ 518,566**	**$ 436,687**
Days receivable	*51.0*	*43.1*

Gross patient care receivables represented 83.3% and 81.1% of total gross receivables as of June 30, 2012 and 2011, respectively. The largest portion of patient care receivables relates to Vanderbilt University Hospitals and Clinics (the Hospital) and in turn the largest component of the Hospital's receivables was from third party payors.

The Hospital provides services to patients in advance of receiving payment and generally does not require collateral or other security for those services. However, the Hospital routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits payable under their health insurance programs, plans, or policies (e.g., Medicare, Medicaid, TennCare, Blue Cross, health maintenance organizations, and commercial insurance policies).

As of June 30, the Hospital had receivables, net of related contractual allowances, including estimated amounts for cost reports and other settlements with government payors, from the following third party payors *(in thousands)*:

	2012	2011
Medicare	$ 49,435	$ 31,375
TennCare/Medicaid	62,274	50,925
Blue Cross	104,168	91,840
Various commercial carriers	171,738	147,275
Total from third party payors	**$ 387,615**	**$ 321,415**

Patient care bad debt expense, reported as a reduction to health care services revenue on the consolidated statements of activities, totaled $112.0 million and $111.0 million as of June 30, 2012 and 2011, respectively.

4. Contributions Receivable

Contributions receivable as of June 30 were as follows *(in thousands)*:

	2012	2011
Unconditional promises expected to be collected:		
in one year or less	$ 31,621	$ 30,052
between one year and five years	50,659	60,509
in more than five years	3,509	2,165
Contributions receivable	85,789	92,726
Less: Unamortized discount	1,798	2,308
Less: Allowance for uncollectible promises	11,657	11,846
Contributions receivable, net	**$ 72,334**	**$ 78,572**

Contributions receivable are discounted at a rate commensurate with the scheduled timing of receipt. Such amounts outstanding as of June 30, 2012 and June 30, 2011, generally were discounted at rates ranging from 0.5% to 2.0%.

The methodology for calculating an allowance for uncollectible promises is based upon Vanderbilt's analysis of write-offs as a percentage of gross pledges receivable along with assessing the age and activity of outstanding pledges.

In addition to pledges reported as contributions receivable, Vanderbilt received bequest intentions of approximately $246.5 million and $241.6 million as of June 30, 2012 and 2011, respectively. These intentions to give are not recognized as assets due to their conditional nature.

Contributions receivable, net as of June 30, were classified as follows *(in thousands)*:

	2012	2011
Contributions receivable, net:		
Temporarily restricted	$ 32,741	$ 27,334
Permanently restricted	39,593	51,238
Total	**$ 72,334**	**$ 78,572**

5. Student Loans and Other Notes Receivable

Student loans and other notes receivable, net, as of June 30 along with related allowances for doubtful accounts were as follows *(in thousands)*:

	2012		2011	
	Net Receivable	Related Allowance	Net Receivable	Related Allowance
Federal loans	$ 17,979	$ 1,780	$ 17,766	$ 1,725
Institutional loans	20,240	2,733	15,353	2,732
Faculty mortgages	7,190	-	7,088	-
Student loans and other notes receivable, net	**$ 45,409**		**$ 40,207**	

Vanderbilt remains committed to "no-loans" for its undergraduate students, meaning that the university is meeting demonstrated financial need solely with grant assistance. For other groups (e.g., graduate students), participation in several federal revolving loan programs, including the Perkins program, has continued. The availability of funds for loans under these programs is dependent on reimbursements to the pool from repayments on outstanding loans. Funds advanced by the federal government ultimately are refundable to the government and are classified as liabilities in the statements of financial position. Outstanding loans cancelled under the program result in a reduction of the funds available for loan and a decrease in the liability to the government.

Allowances for doubtful accounts are established based on prior collection experience and current economic factors which, in management's judgment, could influence the ability of loan recipients to repay amounts due. Institutional loan balances are written off only when they are deemed to be permanently uncollectible.

As part of Vanderbilt's efforts to attract and retain a world-class faculty, Vanderbilt provides home mortgage financing assistance. Notes receivable amounting to $7.2 million were outstanding at June 30, 2012. These notes are collateralized by deeds of trust on properties concentrated in the surrounding region. No allowance for doubtful accounts has been recorded against these loans based on their collateralization and prior collection history.

6. Investments

The fair value of investments consists of the following as of June 30 *(in thousands)*:

	2012	2011
Derivative contract collateral and short-term securities[1]	$ 259,835	$ 95,249
Equity investments		
Developed market equities [2]	138,400	165,067
Emerging market equities [2]	379,499	473,727
Fixed income [1]	451,220	359,580
Absolute return [2]	678,064	751,522
Other hedge funds [2]	360,369	301,037
Private equity [3]	745,136	754,233
Venture capital [3]	433,306	395,798
Real estate [3]	322,856	269,553
Natural resources [3]	274,183	255,343
Equity method securities and trusts[4]	18,082	18,367
Other investments[4]	12,450	23,955
Total fair value	**$ 4,073,400**	**$ 3,863,431**
Total cost	**$ 3,570,332**	**$ 3,318,454**

[1] Fair value is based primarily on quoted prices in active markets.
[2] Fair value is based on the net asset value per share of the specifc investments as provided by the fund managers.
[3] Fair value is based on the net asset value of Vanderbilt's ownership interests at the fund level as provided by the fund managers.
[4] Carrying value provides a reasonable estimate of fair value for certain components.

Included in the amounts reported in the table above are investments allocable to noncontrolling interests (i.e., minority limited partners) reported at fair value. During fiscal 2012, the minority limited partners funded capital commitments totaling $38.7 million. Additionally, Vanderbilt made payments to the minority limited partners of $40.8 million reflecting a distribution of earnings and returned capital from the underlying private fund assets. For the year ended June 30, 2012, the minority limited partners' interests in the results of the underlying returns from the private fund assets were $176.1 million. The balance of unrestricted net assets related to noncontrolling interests, calculated in accordance with the partnership agreements, was $201.4 million as of June 30, 2012.

Investments, along with cash and cash equivalents, provide liquidity support for Vanderbilt's operations. Of these combined amounts, based on prevailing market conditions as of June 30, 2012, $792.4 million was available on a same-day basis and an additional $893.1 million was available within 30 days.

Excluding derivative instruments that may be held by investment managers as part of their respective investment strategies, Vanderbilt held financial futures derivative contracts with notional values of $729.2 million and $575.7 million as of June 30, 2012 and 2011, respectively. The fair market value of such contracts is settled daily between counterparties.

Short-term securities and derivative contract collateral are comprised primarily of amounts posted as collateral in accordance with interest rate exchange agreements and unspent bond proceeds with trustees.

Equity investments consist of investment funds globally diversified across public markets including U.S. markets, other developed markets, and emerging markets. Fund managers of these investments have the ability to shift investments from value to growth strategies, from small to large capitalization stocks, and from a net long position to a net short position.

> ***Developed market equities*** are comprised of investments in U.S. common stocks and other developed countries whose markets have a relatively high level of economic growth and security.
>
> ***Emerging market equities*** include investments in the emerging global economies as defined by Morgan Stanley Capital International (MSCI) Emerging Markets Index.

Fixed income investments are directed towards capital preservation and predictable yield as well as more opportunistic strategies focused on generating return on price appreciation. These investments generally consist of U.S. Treasury debt securities, but may also include other highly liquid debt securities.

Absolute return investments reflect multiple strategies such as event driven, relative value, and equity funds to diversify risks and reduce volatility in the portfolio generally in hedge fund structures.

Other hedge fund investments include investments in both long and short primarily credit-oriented securities. Investments may include mortgage backed securities, trade finance, debt and asset-backed securities, repurchase agreements, senior loans, and bank loans.

Private equity includes investments that participate primarily in leveraged buyout strategies. Distributions from these investments are received through liquidations of the underlying assets. These investments generally are held in commingled limited partnership funds.

Venture capital consists of investments that participate in early-stage, high-potential, high-risk, growth startup companies. These investments generally are held in commingled limited partnership funds. Distributions from these investments are received through liquidations of the underlying assets.

Real estate is comprised of illiquid investments in residential and commercial real estate assets, projects, or land held directly or in commingled limited partnership funds. The nature of the investments in this category is such that distributions generally reflect liquidation of the underlying assets of the funds.

Natural resources includes illiquid investments in timber, oil and gas production, mining, energy, and related services businesses held directly or in commingled limited partnership funds.

Equity method securities and trusts are investments in joint ventures accounted for under the equity method of accounting and Vanderbilt's split-interest agreements with donors.

7. Endowment

The endowment represents only those related net assets that are under the control of Vanderbilt. Endowment-related assets include donor-restricted endowments and institutional endowments (quasi-endowments). Gift annuities, interests in trusts held by others, contributions pending donor designation, and permanently restricted contributions receivable are not considered components of the endowment.

The Board of Trust's interpretation of its fiduciary responsibilities for donor-restricted endowments under the Uniform Prudent Management of Institutional Funds Act (UPMIFA) requirements, barring the existence of any donor-specific provisions, is to preserve intergenerational equity. Under this broad guideline, future endowment beneficiaries should receive at least the same level of economic support as the current generation. The overarching objective is to preserve and enhance the real (inflation-adjusted) purchasing power of the endowment in perpetuity. Assets are invested to provide a relatively predictable and stable stream of earnings to meet spending needs and attain long-term return objectives without the assumption of undue risks.

UPMIFA specifies that unless stated otherwise in a gift instrument, donor-restricted assets in an endowment fund are restricted assets until appropriated for expenditure. Barring the existence of specific instructions in gift agreements for donor-restricted endowments, Vanderbilt reports the historical value for such endowments as permanently restricted net assets and the net accumulated appreciation as temporarily restricted net assets. In this context, historical value represents the original value of initial contributions restricted as permanent endowments plus the original value of subsequent contributions and, if applicable, the value of accumulations made in accordance with the direction of specific donor gift agreements.

Specific appropriation for expenditure of Vanderbilt's endowment funds occurs each spring when the Board of Trust approves the university's operating budget for the ensuing fiscal year. For fiscal years 2012 and 2011, Vanderbilt's Board of Trust approved endowment distributions based on 4.5% of the average of the previous three calendar year-end market values. Actual realized endowment return earned in excess of distributions is reinvested as part of Vanderbilt's endowment. For years where actual endowment return is less than the distribution, the shortfall is covered by the endowment pool's cumulative returns from prior years.

Board-appropriated endowment distributions may not be fully expended during a particular fiscal year. In some cases, endowment distributions may be approved for reinvestment into the endowment.

A summary of Vanderbilt's endowment for the fiscal years ended June 30 follows (*in thousands*):

2012

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowments at historical value	$ -	$ 26,889	$ 962,796	$ 989,685
Accumulated net appreciation of donor-restricted endowments	-	1,040,036	-	1,040,036
Reinvested distributions of donor-restricted endowments				
At historical value	133,836	1,641	-	135,477
Accumulated net appreciation	144,321	1,767	-	146,088
Institutional endowments				
At historical value	208,716	-	-	208,716
Accumulated net appreciation	840,034	-	-	840,034
Endowment net assets as of June 30, 2012	**$ 1,326,907**	**$ 1,070,333**	**$ 962,796**	**$ 3,360,036**

2011

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowments at historical value	$ -	$ 26,564	$ 910,750	$ 937,314
Accumulated net appreciation of donor-restricted endowments	-	1,102,607	-	1,102,607
Reinvested distributions of donor-restricted endowments				
At historical value	129,010	1,727	-	130,737
Accumulated net appreciation	177,185	2,178	-	179,363
Institutional endowments				
At historical value	177,826	-	-	177,826
Accumulated net appreciation	847,306	-	-	847,306
Endowment net assets as of June 30, 2011	**$ 1,331,327**	**$ 1,133,076**	**$ 910,750**	**$ 3,375,153**

The components of the life-to-date accumulated net appreciation of pooled endowments as of June 30 were as follows *(in thousands)*:

	2012	2011
Net realized appreciation less endowment distributions	$ 1,644,115	$ 1,712,298
Net unrealized appreciation	382,043	416,978
Total	**$ 2,026,158**	**$ 2,129,276**

In striving to meet the overarching objectives for the endowment, over the past 20 years, there has been an 11% annualized standard deviation in Vanderbilt's returns. This level of risk is consistent with that accepted by peer institutions. Currently, the endowment portfolio consists of three primary components, each of which is designed to serve a specific role in establishing the right balance between risk and return. Global public and private equity investments, including venture capital and many hedge funds, are expected to produce favorable returns in environments of accelerated growth and economic expansion. Absolute return and fixed income investments are expected to generate stable returns and preserve capital during periods of poor equity performance. Real estate and natural resources allocations are designed to provide an inflation hedge.

From time to time, the fair value of assets associated with an endowed fund may fall below the level that a donor or UPMIFA requires in terms of maintenance of perpetual duration endowments. As of June 30, 2012 and 2011, Vanderbilt had deficiencies of this nature of approximately $11 million and $7 million, respectively. These deficiencies resulted from unfavorable market declines that occurred after the investment of recent permanently restricted contributions. Vanderbilt believes these declines are modest in relation to the total market value for donor-restricted endowments and that these deficiencies will be relatively short-term in nature. Changes in endowment net assets for the fiscal years ended June 30 were as follows *(in thousands)*:

2012

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets as of June 30, 2011	$ 1,331,327	$ 1,133,076	$ 910,750	$ 3,375,153
Endowment investment return:				
Investment income, net of fees	15,725	24,672	-	40,397
Net appreciation (realized and unrealized)	4,848	7,607	-	12,455
Total endowment investment return	20,573	32,279	-	52,852
Gifts and additions to endowment, net	35,722	240	52,046	88,008
Endowment distributions	(57,569)	(90,326)	-	(147,895)
Transfers for internal management costs	(3,385)	(5,311)	-	(8,696)
Other	239	375	-	614
Endowment net assets as of June 30, 2012	**$ 1,326,907**	**$ 1,070,333**	**$ 962,796**	**$ 3,360,036**

2011

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets as of June 30, 2010	$ 1,195,501	$ 970,579	$ 841,527	$ 3,007,607
Endowment investment return:				
Investment income, net of fees	4,039	6,393	-	10,432
Net appreciation (realized and unrealized)	153,571	243,078	-	396,649
Total endowment investment return	157,610	249,471	-	407,081
Gifts and additions to endowment, net	38,845	8,992	69,223	117,060
Endowment distributions	(58,950)	(93,308)	-	(152,258)
Transfers for internal management costs	(2,045)	(3,237)	-	(5,282)
Other	366	579	-	945
Endowment net assets as of June 30, 2011	**$ 1,331,327**	**$ 1,133,076**	**$ 910,750**	**$ 3,375,153**

8. Investment Return

A summary of investment return, including endowment distributions, by net asset category for the fiscal years ended June 30 follows *(in thousands)*:

	2012	2011
OPERATING		
Unrestricted:		
Endowment distributions	$ 136,883	$ 142,252
Investment income	19,831	14,666
Total operating return	**156,714**	**156,918**
NONOPERATING		
Unrestricted:		
Change in appreciation of institutional endowments, net of distributions	(31,447)	102,258
Change in appreciation of self-insurance assets	876	11,299
Investment (loss) income	(2,476)	13,767
Temporarily restricted:		
Endowment distributions	8,565	7,450
Investment income	276	13,583
Change in appreciation of donor-restricted endowments, net of distributions	(62,982)	153,510
Permanently restricted:		
Endowment distributions	2,447	2,556
Investment (loss) income	(969)	6,062
Total nonoperating return	**(85,710)**	**310,485**
Total investment return	**$ 71,004**	**$ 467,403**

The components of total investment return for the fiscal years ended June 30 were as follows *(in thousands)*:

	2012	2011
Net interest, dividend, and partnership income	$ 54,210	$ 100,614
Net realized gains from original cost	56,783	56,526
Change in unrealized appreciation	(39,989)	310,263
Total investment return	**$ 71,004**	**$ 467,403**

In addition to a core group of investment professionals dedicated to the management of Vanderbilt's endowment, Vanderbilt also employs external investment managers. Particularly for alternative investments such as hedge funds, investment manager fee structures frequently have a base component along with a performance component relative to the entire life of the investments. Under these arrangements, management fees frequently are subject to substantial adjustments based on cumulative future returns for a number of years hence.

Investment returns are reported net of returns attributed to limited partners on investments allocable to noncontrolling interests. Investment returns are also reported net of internal management costs of $8.7 million in fiscal 2012 and $5.3 million in fiscal 2011.

Fees paid directly to external investment managers (i.e., segregated investment account fees) totaled $9.0 million and $10.7 million in fiscal 2012 and 2011, respectively.

9. Property, Plant, and Equipment

Property, plant, and equipment as of June 30 were as follows *(in thousands)*:

	2012	2011
Land	$ 73,859	$ 71,494
Buildings and improvements	2,657,197	2,587,239
Moveable equipment	879,482	830,102
Construction in progress	55,264	38,161
Property, plant, and equipment	3,665,802	3,526,996
Less: Accumulated depreciation	1,938,191	1,772,472
Property, plant, and equipment, net	**$ 1,727,611**	**$ 1,754,524**

Purchases for the library collection are not included in the amounts above since they are expensed at the time of purchase. As of June 30, 2012, the estimated replacement cost for library collections, including processing costs to properly identify, catalog, and shelve materials, totaled about $293 million.

Capitalized interest of $0.8 million in fiscal 2011 was added to construction in progress and/or buildings and improvements; no interest was capitalized in fiscal 2012.

Internally developed software costs of $5.8 million and $5.4 million were capitalized in fiscal 2012 and 2011, respectively.

Vanderbilt has identified conditional asset retirement obligations, primarily for the costs of asbestos removal and disposal, resulting in liabilities of $20.0 million and $19.3 million as of June 30, 2012 and 2011, respectively. These liabilities, which are estimated using an inflation rate of 4.0% and a discount rate of 5.0% based on relevant factors at origination, are included in accounts payable and accrued liabilities in the consolidated statements of financial position.

10. Long-Term Debt, Capital Leases, and Commercial Paper

Long-term debt consists of bonds and notes payable with scheduled final maturity dates at least one year after the original issuance date. Outstanding long-term debt, capital leases, and commercial paper (CP) obligations are reflected in the financial statements at carrying value and, as of June 30, were as follows *(in thousands)*:

	Years to Nominal Maturity	Outstanding Fixed Coupon Interest Rates as of June 30, 2012	Fiscal 2012 Effective Interest Rate[2]	Outstanding Principal 2012	Outstanding Principal 2011
FIXED-RATE DEBT					
Series 1998B	17	-	5.0%	$ -	$ 29,705
Series 1998C[1]	3	-	5.0%	-	8,850
Series 2001A	4	-	5.0%	-	7,660
Series 2001B[1]	11	-	5.0%	-	42,585
Series 2008A	7	4.50%-5.00%	4.0%	122,600	127,600
Series 2008B[1]	7	4.00%-5.00%	3.9%	105,710	111,400
Series 2009A	28	4.00%-5.50%	4.9%	97,100	97,100
Series 2009B[1]	28	5.00%-5.50%	5.0%	232,900	232,900
Series 2009A Taxable	7	5.25%	5.0%	250,000	250,000
Series 2012C	6	2.00%-5.00%	0.8%	42,315	-
Fixed-rate debt			4.7%	**850,625**	**907,800**
VARIABLE-RATE DEBT					
Series 2000A	19		0.2%	53,300	54,900
Series 2000B	19		0.2%	-	54,900
Series 2002A	21		0.2%	-	19,260
Series 2003A[1]	7		0.2%	-	20,900
Series 2005A	33		0.2%	68,000	113,300
Series 2012A	27		0.6%	67,000	-
Series 2012B	27		0.8%	67,000	-
Variable-rate debt			0.2%	**255,300**	**263,260**
Par amount of long-term debt			3.7%	1,105,925	1,171,060
Net unamortized premium			-	9,115	3,768
Total long-term debt			3.7%	1,115,040	1,174,828
Capital leases	1 to 3		4.7%	1,989	3,703
Total long-term debt and capital leases			**3.7%**	**1,117,029**	**1,178,531**
Tax-exempt commercial paper	<1		0.3%	149,205	150,000
Taxable commercial paper	<1		0.3%	114,870	114,862
Total commercial paper			**0.3%**	**264,075**	**264,862**
Total long-term debt, capital leases, and commercial paper			**3.1%**	**$ 1,381,104**	**$ 1,443,393**

[1] Issued under Master Trust Indenture structure.
[2] Exclusive of interest rate exchange agreements. Inclusive of these agreements, the overall portfolio effective interest rate was 4.9%.

The preceding table reflects fixed/variable allocations before the effects of interest rate exchange agreements. Such agreements are covered in more detail in a successive note.

Tax-exempt CP and all of the aforementioned bonds (with the exception of the Series 2009A Taxable notes) have been issued by the Health and Educational Facilities Board of The Metropolitan Government of Nashville and Davidson County, Tennessee (HEFB). As a conduit issuer, the HEFB loans the debt proceeds to Vanderbilt. Pursuant to loan agreements, Vanderbilt's debt service requirements under these loan agreements coincide with required debt service of the actual HEFB bonds.

All debt instruments are general obligations of Vanderbilt. No assets are pledged as collateral for such debt.

Included in the foregoing table are hospital and clinic (patient care) bonds, with a principal balance outstanding of $338.6 million as of June 30, 2012, that were issued under a Master Trust Indenture (MTI) structure. The MTI provides the flexibility for multiple parties to participate in debt issuances as part of an obligated group; presently, Vanderbilt's hospitals and clinics have no other members participating in the obligated group. Bonds issued under the MTI are payable from hospital revenues. All outstanding MTI bonds are also supplemented by a Vanderbilt guarantee of debt service.

Trust indentures for certain bond issues contain covenants and restrictions involving the issuance of additional debt, maintenance of a specified debt service coverage ratio, and the maintenance of liquidity facilities. Vanderbilt was in compliance with such covenants and restrictions as of June 30, 2012.

Selected information for debt, CP, and interest rate exchange agreements follows *(in thousands)*:

	2012	2011
Payments for interest costs	$ 72,125	$ 79,126
Accrued interest expense	$ 67,977	$ 74,794

Payments for interest costs, including amounts capitalized, occur on varying scheduled payment dates for debt, maturity dates for CP, and settlement dates for interest rate exchange agreements. Accrued interest expense is based on applicable interest rates for Vanderbilt's debt, CP, and interest rate exchange agreements for the respective fiscal year.

Principal retirements and scheduled sinking fund requirements based on nominal maturity schedules for long-term debt due in subsequent fiscal years ending June 30 are as follows *(in thousands)*:

2013	$ 33,190
2014	34,530
2015	36,200
2016	50,065
2017	40,505
Thereafter	911,435
Total long-term debt principal retirements	**$ 1,105,925**

In addition to scheduled principal and interest payments on long-term debt obligations, Vanderbilt's capital lease agreements outstanding as of June 30, 2012, will require payments of $1.5 million during fiscal 2013. Of those payments, $1.4 million will be allocated toward amortizing the $1.9 million capital lease obligation. Furthermore, requirements noted in the preceding table could be greater if Vanderbilt must purchase either a portion or all of its variable-rate demand obligations, floating-rate notes, and CP in the event of failed remarketings on the respective weekly reset dates, mandatory tender dates, or scheduled maturities as described in the following paragraphs.

Vanderbilt had $255.3 million of variable-rate bonds outstanding as of June 30, 2012, consisting of $121.3 million of weekly variable-rate demand obligations and $134.0 million of floating-rate notes with mandatory tender dates of October 1, 2015 and 2017. During fiscal 2011, all of Vanderbilt's variable-rate bonds were in weekly interest rate reset modes. In the event that Vanderbilt receives notice of an optional tender on its variable-rate demand obligations, the purchase price of the bonds will be paid from the remarketing of such bonds. If the remarketing proceeds are insufficient, Vanderbilt will have a current obligation to purchase the bonds tendered.

As of June 30, 2012, Vanderbilt had $149.2 million of tax-exempt CP outstanding and $114.9 million of taxable CP outstanding. Vanderbilt can issue up to a combined $675.0 million under its tax-exempt and taxable CP programs. However, issuance of incremental taxable CP beyond that outstanding as of June 30, 2012, would require approval by Vanderbilt's Board of Trust, and issuance of incremental tax-exempt CP would require approval by both Vanderbilt's Board of Trust and the HEFB as conduit issuer.

The weighted average duration of Vanderbilt's CP portfolio totaled 151 days as of June 30, 2012, and 96 days as of June 30, 2011.

Liquidity support for debt with short-term remarketing periods (weekly reset variable-rate bonds and CP totaling $385.4 million) is provided by Vanderbilt's self-liquidity. As of June 30, 2012, Vanderbilt estimates that $792.4 million of liquid assets were available on a same-day basis and an additional $893.1 million was available within 30 days.

A second tier of liquidity support consists of two bank revolving credit facilities with maximum available commitments totaling $200.0 million as of June 30, 2012, dedicated solely to Vanderbilt's debt portfolio liquidity support. These commitments expire in March 2013 and March 2014. Maximum repayment periods, which may extend beyond the expiration dates, range from 90 days to three years. Vanderbilt has never borrowed against revolving credit agreements to support redemptions of debt.

Vanderbilt has also entered into agreements with two banks to provide general use lines of credit with maximum available commitments totaling $300.0 million as of June 30, 2012. These lines of credit, which may be drawn upon for general operating purposes, expire in June 2013 and October 2014. No amounts were drawn on these credit facilities as of June 30, 2012 or June 30, 2011.

Vanderbilt's long-term debt is reported at carrying value, which is the par amount adjusted for the net unamortized amount of bond premiums and discounts. The carrying value and estimated market value of Vanderbilt's long-term debt as of June 30 were as follows (*in thousands*):

	2012	2011
Carrying value of long-term debt	$ 1,115,040	$ 1,174,828
Market value of long-term debt	$ 1,205,749	$ 1,237,561

The estimated market value of Vanderbilt's long-term debt is based on market conditions prevailing at fiscal year-end reporting dates. Besides potentially volatile market conditions, market value estimates typically also reflect limited secondary market trading. Vanderbilt's capital leases and commercial paper are also reported at carrying value, which closely approximates market value for those liabilities.

On October 1, 2011, Vanderbilt fully redeemed the remaining principal maturities of the Series 1998B and 1998C fixed-rate bonds

On March 29, 2012, Vanderbilt issued the Series 2012A, 2012B, and 2012C bonds aggregating $176.3 million for the purpose of redeeming weekly reset variable-rate debt and callable fixed-rate debt. The Series 2012A and 2012B variable-rate bonds (floating-rate notes) were issued in the amount of $134.0 million and bear interest initially at fixed spreads to weekly SIFMA resets of 0.40% and 0.60%, respectively, through the initial mandatory tender dates of October 1, 2015 and October 1, 2017, respectively, and final maturity dates of October 1, 2038. Series 2012A and 2012B proceeds were used to fund the full redemption of Vanderbilt's variable-rate Series 2000B, 2002B, and 2003A and a partial redemption of Series 2005A. The Series 2012C fixed-rate bonds were issued in the par amount of $42.3 million and include an original issue premium of $3.9 million. The Series 2012C bonds are noncallable with an an average coupon of 4.7% and a final maturity of October 1, 2017. Par and premium proceeds from the Series 2012C issuance fully funded the redemption of Series 2001A and 2001B fixed-rate principal maturities due after May 1, 2012. This refunding produced a $0.8 million accounting loss reported as other nonoperating in the consolidated statement of activities and resulted in present value savings of $6.7 million.

None of Vanderbilt's fixed-rate debt has a mandatory tender date preceding the respective final maturity dates. The Series 2008A and 2008B bonds include amortizing principal amounts each year but these bonds are noncallable before their October 2018 final maturity date. The Series 2009A and 2009B bonds include amortizing principal amounts each year beginning fiscal 2016 and these bonds may be called at par beginning October 2019. The Series 2009A Taxable notes do not amortize and are callable before the April 2019 maturity date only if Vanderbilt pays a make-whole call provision to the bondholders. The Series 2012C bonds include annual amortizing principal amounts beginning October 2012, excluding October 2015, until their final maturity in October 2017.

11. Interest Rate Exchange Agreements

Vanderbilt has entered into interest rate exchange agreements as part of its debt portfolio management strategy. These agreements result in periodic net cash settlements paid to, or received from, counterparties. Net settlements due to counterparties totaled $25.5 million and $29.9 million in fiscal 2012 and 2011, respectively, and were reflected as adjustments to interest expense.

The fair value of interest rate exchange agreements is based on the present value sum of future net cash settlements that reflect market yields as of the measurement date and reflects estimated amounts that Vanderbilt would pay, or receive, to terminate the contracts as of the report date. The estimated fair value of Vanderbilt's outstanding interest rate exchange agreements was a liability of $315.6 million and a liability of $135.0 million as of June 30, 2012 and 2011, respectively.

Vanderbilt did not enter into any new interest rate exchange agreements during fiscal 2012 or 2011. Vanderbilt allowed a $500.0 million fixed-receiver interest rate exchange contract option to expire. This option had zero intrinsic value on the expiration date of December 1, 2010.

During fiscal 2011, Vanderbilt terminated $280.0 million of fixed-payer interest rate exchange agreements at a net cost of $23.7 million to reduce collateral exposure and eliminate ongoing settlement costs as reported in the nonoperating section of the consolidated statement of activities.

Gains and losses from changes in the fair value of interest rate exchange agreements are reported in the nonoperating section of the consolidated statements of activities. These changes resulted in net losses of $180.6 million in fiscal 2012 and net gains of $72.1 million in fiscal 2011.

The interest rate exchange agreements include collateral pledging requirements based on the fair value of the contracts. Collateral held by counterparties as of June 30, 2012 and 2011, totaled $236.2 million and $81.4 million, respectively. Vanderbilt estimates that a decline in long-term LIBOR rates to approximately 2% would result in the fair value of the portfolio being a liability of approximately $400 million and correspondingly increase Vanderbilt's collateral pledging requirements to approximately $310 million. As of June 30, 2012, 30-year LIBOR was 2.51%.

As of June 30, 2012, Vanderbilt's adjusted debt portfolio, after taking into account outstanding fixed-payer interest rate exchange agreements, was approximately 115% fixed.

The notional amounts of Vanderbilt's outstanding interest rate exchange agreements as of June 30 were as follows *(in thousands)*:

Description	Rate Paid	Rate Received	Maturity	2012	2011
Fixed-payer interest rate exchange agreements[1]	Avg fixed rate of 3.72%	Avg of 68.3% of one-month LIBOR[2]	19 to 33 years	$ 721,600	$ 724,800
Basis interest rate exchange agreements	SIFMA[3]	Avg of 81.5% of one-month LIBOR[2]	23 to 24 years	$ 500,000	$ 500,000

[1] For one amortizing fixed-payer interest rate exchange agreement that will have a notional balance of $51.6 million in October 2012, the counterparty may exercise an option to terminate the contract, in whole or in part and at no cost, at any time from that date until the final maturity in October 2030.
[2] LIBOR (London Interbank Offered Rate) is a reference rate based on interest rates at which global banks borrow funds from other banks in the London interbank lending market.
[3] SIFMA (Securities Industry and Financial Markets Association) is a seven day high-grade market index rate based upon tax-exempt variable rate debt obligations.

12. Net Assets

Unrestricted net assets are internally designated into the following groups:

Designated for operations represents the cumulative operating activity of Vanderbilt and plant replacement reserves. These net assets also reflect the realized losses of derivative financing activities.

Designated gifts and grants are composed of gift and grant funds.

Designated for student loans represents Vanderbilt funds set aside to serve as revolving loan funds for students.

Designated for plant facilities represents (a) Vanderbilt's investment in property, plant, and equipment, net of accumulated depreciation, as well as (b) funds designated for active construction projects and retirement of capital-related debt, offset by (c) Vanderbilt's conditional asset retirement obligation.

Reinvested distributions of donor-restricted endowments at historical value are amounts related to donor-restricted endowments that are reinvested in the endowment in accordance with donor requests.

Accumulated net appreciation of reinvested distributions represents cumulative appreciation on reinvestments of donor-restricted endowments.

Institutional endowments (quasi-endowments) *at historical value* are amounts set aside by Vanderbilt to generate income in perpetuity to support operating needs.

Accumulated net appreciation of institutional endowments represents cumulative appreciation on institutional endowments.

Fair value of interest rate exchange agreements, net represents the mark-to-market valuation for such contracts. Because these agreements are intended to manage interest rate risks within the debt portfolio, segregation from other designations is maintained.

Net assets related to noncontrolling interests represents minority partners' share of the equity in two partnerships (endowment private equity and real estate partnerships) formed to acquire, hold, and manage private fund assets.

Based on the foregoing designations, unrestricted net assets as of June 30 were as follows *(in thousands)*:

	2012	2011
Designated for operations	$ 693,025	$ 531,460
Designated gifts and grants	118,023	164,683
Designated for student loans	22,480	25,851
Designated for plant facilities	714,944	685,102
Reinvested distributions of donor-restricted endowments at historical value	133,836	129,010
Accumulated net appreciation of reinvested distributions	144,321	177,185
Institutional endowments at historical value	208,716	177,826
Accumulated net appreciation of institutional endowments	840,034	847,306
Fair value of interest rate exchange agreements, net	(315,577)	(135,026)
Net assets related to noncontrolling interests	201,386	199,249
Total unrestricted net assets	**$ 2,761,188**	**$ 2,802,646**

Temporarily restricted net assets as of June 30 were composed of the following *(in thousands)*:

	2012	2011
Donor-restricted endowments at historical value	$ 26,889	$ 26,564
Accumulated net appreciation of donor-restricted endowments	1,040,036	1,102,607
Reinvested distributions of donor-restricted endowments at historical value	1,641	1,727
Accumulated net appreciation of reinvested distributions	1,767	2,178
Contributions	101,603	102,749
Interests in trusts held by others	6,826	6,991
Life income and gift annuities	12,454	19,455
Total temporarily restricted net assets	**$ 1,191,216**	**$ 1,262,271**

Such temporarily restricted net assets were designated for the following purposes as of June 30 *(in thousands)*:

	2012	2011
Student scholarships	$ 223,133	$ 301,756
Instruction	463,067	518,648
Capital improvements	16,183	11,831
Subsequent period operations and other	488,833	430,036
Total temporarily restricted net assets	**$ 1,191,216**	**$ 1,262,271**

Permanently restricted net assets as of June 30 were composed of the following *(in thousands)*:

	2012	2011
Donor-restricted endowments at historical value	$ 962,796	$ 910,750
Contributions	40,101	53,125
Interests in trusts held by others	32,431	32,370
Life income and gift annuities	31,816	29,357
Total permanently restricted net assets	**$ 1,067,144**	**$ 1,025,602**

Based on relative fair values as of June 30, 2012, approximately 21% of donor-restricted endowments support scholarships, 20% support endowed chairs, 23% support operations, and 36% were for other purposes.

13. Fair Value Measurement

Vanderbilt utilizes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value into three levels:

Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities that are accessible at the measurement date.

Level 2 inputs are inputs other than quoted prices included in Level 1 that are either directly or indirectly observable for the assets or liabilities.

Level 3 inputs are unobservable inputs for the assets or liabilities.

The level in the fair value hierarchy within which a fair value measurement in its entirety is classified based on the lowest level input that is significant to the fair value measurement.

The classification of a financial instrument within level 3 is based on the significance of the unobservable inputs to the overall fair value measurement.

All net realized and unrealized gains and losses on level 3 investments are reflected in the consolidated statements of activities as changes in endowment appreciation or changes in appreciation of other investments. Gains and losses on investments allocable to noncontrolling interests are reported as a component of net endowment appreciation in the consolidated statements of activities. Net realized and unrealized gains and losses on interests in trusts held

by others are reported as changes in appreciation of other investments in the consolidated statements of activities.

Rollforwards of amounts for level 3 financial instruments for the fiscal years ended June 30 follow *(in thousands)*:

	June 30, 2011	Realized and unrealized gains (losses)	Purchases	Sales	Transfers into and (out) of level 3	June 30, 2012	Change in unrealized gains (losses) for investments still held at June 30, 2012
LEVEL 3 ASSETS							
Developed market equities	$ 70,225	(7,295)	7,867	(38,274)	-	32,523	(3,014)
Emerging market equities	134,448	(19,855)	-	(6,250)	-	108,343	(19,856)
Fixed income	19,706	581	6,981	(7,514)	-	19,754	(1,249)
Absolute return	612,815	(24,022)	5,773	(86,577)	-	507,989	(122,215)
Other hedge funds	182,937	8,751	-	-	-	191,688	8,751
Private equity	754,233	4,088	89,647	(102,832)	-	745,136	43,423
Venture capital	395,621	35,724	69,996	(68,035)	-	433,306	2,125
Real estate	269,553	43,565	45,694	(35,956)	-	322,856	170,196
Natural resources	255,343	11,695	37,948	(30,803)	-	274,183	(10,629)
Equity method securities and trusts	18,367	7,847	3,609	(3,424)	(8,317)	18,082	(7,032)
Other investments	23,779	(6,344)	2,793	(8,133)	214	12,309	17,325
Interests in trusts held by others	39,362	(105)	-	-	-	39,257	(105)
Total Level 3	**$ 2,776,389**	**$ 54,630**	**$ 270,308**	**$ (387,798)**	**$ (8,103)**	**$ 2,705,426**	**$ 77,720**

	June 30, 2010	Realized and unrealized gains (losses)	Purchases	Sales	Transfers into and (out) of level 3	June 30, 2011	Change in unrealized gains (losses) for investments still held at June 30, 2011
LEVEL 3 ASSETS							
Developed market equities	$ 217,019	$ 8,564	$ $ 7,208	$ (133,365)	$ (29,201)	$ 70,225	$ (24,860)
Emerging market equities	211,945	33,083	3,750	(80,797)	(33,533)	134,448	32,287
Fixed income	20,294	228	2,519	(3,335)	-	19,706	-
Absolute return	548,293	52,417	83,962	(114,226)	42,369	612,815	39,814
Other hedge funds	193,755	9,243	-	(20,061)	-	182,937	9,243
Private equity	562,285	154,906	117,747	(80,705)	-	754,233	65,502
Venture capital	253,419	96,003	91,851	(45,652)	-	395,621	83,916
Real estate	219,044	19,191	47,335	(16,017)	-	269,553	19,803
Natural resources	214,468	27,053	46,539	(32,717)	-	255,343	25,203
Equity method securities and trusts	21,368	10,692	-	(10,870)	(2,823)	18,367	-
Other investments	24,823	(874)	154	(324)	-	23,779	276
Interests in trusts held by others	36,393	2,969	-	-	-	39,362	-
Total Level 3	**$ 2,523,106**	**$ 413,475**	**$ 401,065**	**$ (538,069)**	**$ (23,188)**	**$ 2,776,389**	**$ 251,184**

The tables on the following pages present the amounts within each valuation hierarchy level for those assets and liabilities carried at fair value: cash and cash equivalents; investments; investments allocable to noncontrolling interests (in Vanderbilt-controlled real estate and other partnerships); interests in trusts held by others; and the fair value of interest rate exchange agreements, net.

As a measure of liquidity, the frequencies that investments may be redeemed or liquidated are also noted in the following tables, along with the numbers of days notice required to liquidate investments.

As of June 30, 2012, 87% of cash and cash equivalents were available on a same-day basis.

Most investments that have been classified as levels 2 and 3 consist of shares or units in investment funds as opposed to direct interests in the funds' underlying holdings. Since the net asset value reported by each fund is used as a practical expedient to estimate the fair value of Vanderbilt's interest therein, its classification within the fair value hierarchy as level 2 or level 3 is based on Vanderbilt's ability to redeem its interest at or near the financial statement date. Vanderbilt defines near-term as within 90 days of the financial statement date.

Derivative contract collateral and short-term securities are comprised primarily of amounts posted as collateral in accordance with interest rate exchange agreements and unspent bond proceeds with

trustees. Vanderbilt deems a redemption or liquidation frequency for these amounts as nonapplicable.

Equities and fixed income provide varying levels of liquidity as defined in the following tables. As of June 30, 2012, 47%, 63%, and 85% of developed market equities value, emerging market equities value, and fixed income value, respectively, were available for daily redemption requests with liquidity within 30 days.

Absolute return and other hedge funds includes daily, quarterly, and annual redemption frequencies. Notice may be provided to the fund managers to exit from the respective funds in the time periods noted.

As of June 30, 2012, 21% of absolute return investments were comprised of hedge funds in "hard lockup" periods of up to 36 months, during which redemptions or liquidations are not allowed per terms of the respective agreements with fund managers. Additionally, 5% of absolute return investments were in "soft lockup" periods of up to nine months, during which redemptions or liquidations may occur but are subject to withdrawal penalties of up to 4.5%.

The total fair values for private equity, venture capital, real estate, natural resources, and other investments were reported as illiquid as of June 30, 2012. These amounts predominantly consist of limited partnerships. Under the terms of these limited partnership agreements, Vanderbilt is obligated to remit additional funding periodically as capital calls are exercised by the general partner. These partnerships have a limited existence and the agreements may provide for annual extensions relative to the timing for disposing portfolio positions and returning capital to investors. Depending on market conditions, the ability or inability of a fund to execute its strategy, and other factors, the general partner may extend the terms or request an extension of terms of a fund beyond its originally anticipated existence or may liquidate the fund prematurely. Vanderbilt cannot anticipate such changes because they are based on unforeseen events. As a result, the timing and amount of future capital calls or distributions in any particular year are uncertain and the related market values are reported as illiquid.

The following tables summarize the fair value measurements and terms for redemptions or liquidations for those assets and liabilities carried at fair value as of June 30 *(in thousands)*:

2012

	Fair Value Measurements				Group	Redemption or Liquidation	Days
	Level 1	Level 2	Level 3	Total	%	Frequency	Notice
ASSETS REPORTED AT FAIR VALUE							
Cash and cash equivalents	$ 912,419	$ -	$ -	$ 912,419	87%	Daily	same-day
					13%	Daily	2-90 days
Derivative contract collateral and short-term securities	259,835	-	-	259,835	100%	n/a	n/a
Equity investments:							
Developed market equities	101,637	4,240	32,523	138,400	47%	Daily	2-30 days
					43%	Daily	>30 days
					3%	Annually	>30 days
					7%	n/a	n/a
Emerging market equities	271,156	-	108,343	379,499	63%	Daily	2-30 days
					22%	Monthly	>30 days
					15%	Quarterly	>30 days
Fixed income	431,466	-	19,754	451,220	51%	Daily	next-day
					34%	Daily	2-30 days
					15%	Daily	>30 days
Absolute return	82,847	87,228	507,989	678,064	5%	Daily	2-30 days
					57%	Quarterly	>30 days
					9%	Annually	>30 days
					26%	Lockup	>30 days
					3%	n/a	n/a
Other hedge funds	-	168,681	191,688	360,369	28%	Daily	>30 days
					27%	Quarterly	>30 days
					45%	Annually	>30 days
Private equity	-	-	745,136	745,136	100%	>1yr	n/a
Venture capital	-	-	433,306	433,306	100%	>1yr	n/a
Real estate	-	-	322,856	322,856	100%	>1yr	n/a
Natural resources	-	-	274,183	274,183	100%	>1yr	n/a
Equity method securities and trusts	-	-	18,082	18,082	100%	n/a	n/a
Other investments	141	-	12,309	12,450	100%	>1yr	n/a
Interests in trusts held by others	-	-	39,257	39,257	100%	n/a	n/a
Total assets reported at fair value	**$ 2,059,501**	**$ 260,149**	**$ 2,705,426**	**$ 5,025,076**			
LIABILITIES REPORTED AT FAIR VALUE							
Interest rate exchange agreements, net	$ -	$ 315,577	$ -	$ 315,577			

2011

	Fair Value Measurements				Group	Redemption or Liquidation	Days
	Level 1	Level 2	Level 3	Total	%	Frequency	Notice
ASSETS REPORTED AT FAIR VALUE							
Cash and cash equivalents	$ 1,129,804	$ -	$ -	$ 1,129,804	98%	Daily	same-day
					2%	Daily	2-90 days
Derivative contract collateral and short-term securities	95,249	-	-	95,249	100%	n/a	n/a
Equity investments:							
Developed market equities	89,052	5,790	70,225	165,067	20%	Daily	next-day
					10%	Daily	2-30 days
					38%	Daily	>30 days
					17%	Quarterly	>30 days
					3%	Annually	>30 days
					12%	n/a	n/a
Emerging market equities	308,631	30,647	134,449	473,727	58%	Daily	2-30 days
					6%	Bi-Weekly	2-30 days
					22%	Monthly	>30 days
					14%	Quarterly	>30 days
Fixed income	339,874	-	19,706	359,580	40%	Daily	next-day
					41%	Daily	2-30 days
					19%	Daily	>30 days
Absolute return	138,707	-	612,815	751,522	8%	Daily	next-day
					58%	Quarterly	>30 days
					31%	Lockup	>30 days
					3%	n/a	n/a
Other hedge funds	-	118,100	182,937	301,037	25%	Quarterly	>30 days
					44%	Annually	>30 days
					31%	Lockup	>30 days
Private equity	-	-	754,233	754,233	100%	>1yr	n/a
Venture capital	177	-	395,621	395,798	100%	>1yr	n/a
Real estate	-	-	269,553	269,553	100%	>1yr	n/a
Natural resources	-	-	255,343	255,343	100%	>1yr	n/a
Equity method securities and trusts	-	-	18,367	18,367	100%	n/a	n/a
Other investments	177	-	23,778	23,955	1%	Daily	>30 days
					99%	n/a	n/a
Interests in trusts held by others	-	-	39,362	39,362	100%	n/a	n/a
Total assets reported at fair value	**$ 2,101,671**	**$ 154,537**	**$ 2,776,389**	**$ 5,032,597**			
LIABILITIES REPORTED AT FAIR VALUE							
Interest rate exchange agreements, net	**$ -**	**$ 135,026**	**$ -**	**$ 135,026**			

14. Natural Classification of Expenses and Allocations

For the fiscal years ended June 30, operating expenses incurred were as follows *(in thousands)*:

	2012	2011
Salaries, wages, and benefits	$ 2,195,716	$ 2,056,804
Services	188,488	188,372
General expenses and supplies	726,116	692,735
Depreciation and amortization	172,718	173,195
Interest	67,977	74,794
Utilities, operating leases, and other	156,385	154,981
Total operating expenses	**$ 3,507,400**	**$ 3,340,881**

Certain allocations of institutional and other support costs were made to Vanderbilt's primary programs. Based on the functional uses of space on its campus, Vanderbilt allocated depreciation and interest on indebtedness to the functional operating expense categories as shown below *(in thousands)*:

2012

	Depreciation	Interest
Instruction	$ 19,295	$ 3,359
Research	27,080	6,276
Health care services	78,548	42,731
Public service	816	100
Academic support	8,241	1,210
Student services	1,207	428
Institutional support	15,117	1,781
Room, board, and other auxiliary services	22,414	12,092
Total	**$ 172,718**	**$ 67,977**

2011

	Depreciation	Interest
Instruction	$ 19,056	$ 5,233
Research	25,067	7,319
Health care services	79,167	41,496
Public service	1,101	300
Academic support	9,410	2,314
Student services	1,404	593
Institutional support	15,174	2,705
Room, board, and other auxiliary services	22,816	14,834
Total	**$ 173,195**	**$ 74,794**

15. Retirement Plans

Vanderbilt's full-time faculty and staff members participate in defined contribution retirement plans administered by third-party investment and insurance firms. For eligible employees with one year of continuous service, these plans require employee and matching employer contributions. Such contributions immediately fully vest with the employee.

Vanderbilt's obligations under these plans are fully funded by monthly transfers to the respective retirement plan administrators with the corresponding expenses recognized in the year incurred. Vanderbilt's retirement plan contributions for fiscal 2012 and 2011 were $59.8 million and $56.2 million, respectively.

16. Student Financial Aid

Vanderbilt provides financial aid to students based upon need and merit. This financial assistance is funded by institutional resources, contributions, endowment distributions, and externally sponsored programs.

In fiscal 2012 and 2011, financial aid for tuition and educational fees of $199.3 million and $193.5 million was applied to gross tuition and educational fees of $449.4 million and $437.4 million, respectively. In fiscal 2012 and 2011, financial aid for room and board of $28.8 million and $27.2 million was applied to gross room and board of $70.1 million and $67.1 million, respectively.

Loans to students from Vanderbilt funds are carried at cost, which, based on secondary market information, approximates the fair value of educational loans with similar interest rates and payment terms. Loans to qualified students historically have been funded principally with government advances to Vanderbilt under the Perkins, Nursing, and Health Professions Student Loan Programs. Loans receivable from students under governmental loan programs, also carried at cost, can only be assigned to the federal government or its designees. Student loan receivables are reported net of allowances for estimated uncollectible accounts of $4.5 million as of June 30, 2012 and 2011.

17. Charity Care Assistance and Community Benefits

Consistent with Vanderbilt's mission, the university's medical center (including hospitals, clinics, and physician practice units) maintains a policy which sets forth the criteria pursuant to those health care services that are provided without expectation of payment, or, at a reduced payment rate to patients who have minimal financial resources to pay for their medical care. These services represent charity care and are not reported as revenue.

The medical center maintains records to identify and monitor the level of charity care it provides, and these records include the amount of gross charges and patient deductibles, co-insurance and co-payments forgone for services furnished under its charity care policy, and the estimated cost of those services. Charity care assistance is offered on a tiered grid, which is based on federal poverty guidelines. In addition to charity care assistance, all uninsured patients are eligible for a discount from billed charges for medically necessary services that is mandated under state of Tennessee law. For those patients with a major catastrophic medical event that does not qualify for full charity assistance, additional discounts are given based on the income level of the patient household using a sliding scale.

The cost of charity care provided by the medical center was $120.1 million and $104.2 million in fiscal 2012 and 2011, respectively. Of the total uncompensated care provided by the medical center (comprising charity care and bad debt reflected as deductions from gross revenue), 78% and 75% of the total in fiscal 2012 and 2011, respectively, was charity care. Charity care services represent 5.7% and 5.4%, respectively, of total patient services at the medical center in fiscal 2012 and 2011.

In addition to the charity care services described above, the medical center provides a number of other services to benefit the economically disadvantaged for which little or no payment is received. TennCare/Medicaid and state indigent programs do not cover the full cost of providing care to beneficiaries of those programs. As a result, in addition to direct charity care costs, the medical center provided services related to TennCare/Medicaid and state indigent programs substantially below the cost of rendering such services.

The medical center also provides public health education and training for new health professionals and provides, without charge, services to the community at large, together with support groups for many patients with special needs.

18. Related Parties

Intermittently, members of Vanderbilt's Board of Trust or Vanderbilt employees may be directly or indirectly associated with companies engaged in business activities with the university. Accordingly, Vanderbilt has a written conflict of interest policy that requires, among other things, that members of the university community (including trustees) may not review, approve, or administratively control contracts or business relationships when (a) the contract or business relationship is between Vanderbilt and a business in which the individual or a family member has a material financial interest or (b) the individual or a family member is an employee of the business and is directly involved with activities pertaining to Vanderbilt.

Furthermore, Vanderbilt's conflict of interest policy extends beyond the foregoing business activities in that disclosure is required for any situation in which an applicable individual's financial, professional, or other personal activities may directly or indirectly affect, or have the appearance of affecting, an individual's professional judgment in exercising any university duty or responsibility, including the conduct or reporting of research.

The policy extends to all members of the university community (including trustees, university officials, and faculty and staff and their immediate family members). Each applicable person is required to certify compliance with the conflict of interest policy on an annual basis. This certification includes specifically disclosing whether Vanderbilt conducts business with an entity in which he or she (or an immediate family member) has a material financial interest as well as any other situation that potentially could be perceived to conflict with Vanderbilt's best interests.

When situations exist relative to the conflict of interest policy, active measures are taken to appropriately manage the actual or perceived conflict in the best interests of the university, including periodic reporting of the measures taken to the Board of Trust Audit Committee.

19. Lease Obligations

Vanderbilt leases certain equipment and real property. These leases are classified primarily as operating leases and have lease terms of up to 15 years. Total operating lease expense in fiscal 2012 and 2011 was $56.1 million and $51.8 million, respectively.

As of June 30, 2012, future committed minimum rentals by fiscal year on significant noncancelable operating leases with initial or remaining lease terms in excess of one year were as follows *(in thousands)*:

2013	$	43,681
2014		31,723
2015		28,539
2016		20,994
2017		16,227
Thereafter		32,803
Total future minimum rentals	**$**	**173,967**

Vanderbilt leases over 50% of the space in the approximately 850,000-square-foot One Hundred Oaks facility, located within five miles of the main campus, primarily for medical clinic and office uses. This operating lease commenced in fiscal 2008 with an initial lease term of 12 years. Minimum aggregate rental payments of $40.5 million related to this space are included in the preceding table.

20. Commitments and Contingencies

(A) *Construction.* As of June 30, 2012, approximately $145.1 million was contractually committed for projects under construction and equipment purchases. The largest components of these commitments were for the second phase of Vanderbilt's residential colleges program, College Halls at Kissam ($93.6 million); floor build-outs in the Critical Care Tower of the adult hospital ($19.8 million); and renovations to Alumni Hall ($11.1 million).

(B) *Litigation.* Vanderbilt is a defendant in several legal actions. Vanderbilt believes that the outcome of these actions will not have a significant effect on Vanderbilt's consolidated financial position.

(C) *Regulations.* Vanderbilt's compliance with regulations and laws is subject to future government reviews and interpretations, as well as regulatory actions unknown or unasserted at this time. Vanderbilt believes that the liability, if any, from such reviews will not have a significant effect on Vanderbilt's consolidated financial position.

(D) *Medical Malpractice Liability Insurance.* Vanderbilt is self-insured for the first level of medical malpractice claims. The current self-insured retention is $5.5 million per occurrence, not to exceed an annual aggregate of $43.0 million. For this self-insured retention, investments have been segregated. The funding for these segregated assets is based upon studies performed by an independent actuarial firm. Excess malpractice and professional liability coverage has been obtained from commercial insurance carriers on a claims-made basis for claims above the retained self-insurance risk levels.

(E) *Employee Health and Workers Compensation Insurance.* Vanderbilt is self-insured for employee health insurance and workers compensation coverage. Vanderbilt's estimated liabilities are based upon studies conducted by independent actuarial firms.

(F) *Federal and State Contracts and Other Requirements.* Expenditures related to federal and state grants and contracts are subject to adjustment based upon review by the granting agencies. The amounts, if any, of expenditures that may be disallowed by the granting agencies and the resultant impact on government grants and contract revenue as well as facilities and administrative cost recovery cannot be determined at this time, although management expects they will not have a significant effect on Vanderbilt's consolidated financial position.

(G) *Health Care Services.* Revenue from health care services includes amounts paid under reimbursement agreements with certain third-party payers and is subject to examination and retroactive adjustments. Any differences between estimated year-end settlements and actual final settlements are reported in the year final settlements are known. Substantially all final settlements have been determined through the year ended June 30, 2007. Cahaba Government Benefit Administrators (Cahaba GBA), Vanderbilt's Medicare Administrative Contractor, has been unable to complete final settlements for more recent years due to data issues at the Centers for Medicare and Medicaid Services (CMS) and other factors such as Cahaba GBA audit backlogs. Final settlements relative to periods through June 30, 2010, are expected to be complete during fiscal 2013.

(H) *HIPAA Compliance.* Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal government has authority to complete fraud and abuse investigations. HIPAA has established substantial fines and penalties for offenders. Vanderbilt continues to refine policies, procedures, and organizational structures to enforce and monitor compliance with HIPAA, as well as other government statutes and regulations.

(I) *Partnership Investment Commitments.* There were $632.8 million of commitments to venture capital, real estate, and private equity investments as of June 30, 2012. These funds may be drawn down over the next several years upon request by the general partners. Vanderbilt expects to finance these commitments with available cash and expected proceeds from the sales of securities. In addition, Vanderbilt is a secondary guarantor for $33.5 million of commitments for certain investment vehicles where minority limited partners in subsidiaries that Vanderbilt controls have the primary obligations.

(J) *McKendree Village, Inc. Debt Guaranty.* In July 1998, Vanderbilt and McKendree Village, Inc. (McKendree), a not-for-profit retirement community, entered into an affiliation agreement, including a guarantee of certain McKendree debt by the university, largely secured by asset liens on McKendree property. The assets of McKendree have been sold to a third party and as of June 30, 2012, the aforementioned McKendree debt has been fully retired. Expectations are that the university's affiliation with McKendree will cease during fiscal 2013.

Attachment C.Contribution to the Orderly Development of Healthcare.7.d

Licensure Certification & Plan of Correction

The Joint Commission

April 27, 2012

Wright Pinson, MBA, MD
Deputy Vice Chancellor for Health Affairs,
CEO
Vanderbilt University Hospital and The
Vanderbilt Clinic
1211 22nd Avenue South
Nashville, TN 37232-2101

Joint Commission ID #: 7892
Program: Advanced Primary Stroke Center
Certification Activity: 45-day Evidence of
Standards Compliance
Certification Activity Completed: 04/27/2012

Dear Dr. Pinson:

The Joint Commission would like to thank your organization for participating in the certification process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the certification process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization a Passed Certification decision for all services reviewed under the applicable manual noted below:

- Disease Specific Care Certification Manual

This certification cycle is effective beginning March 14, 2012. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 24 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your certification decision.

We encourage you to share this certification decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the state or regional regulatory services, and the public you serve of your organization's certification decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

The Joint Commission

April 20, 2012

Wright Pinson, MBA, MD
Deputy Vice Chancellor for Health Affairs,
CEO
Vanderbilt University Hospital and The
Vanderbilt Clinic
1211 22nd Avenue South
Nashville, TN 37232-2101

Joint Commission ID #: 7892
Program: Advanced Ventricular Assist Device
Certification Activity: Initial Full Event
Certification Activity Completed: 04/20/2012

Dear Dr. Pinson:

The Joint Commission would like to thank your organization for participating in the certification process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the certification process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization a Passed Certification decision for all services reviewed under the applicable manual noted below:

- Disease Specific Care Certification Manual

This certification cycle is effective beginning April 21, 2012. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 24 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your certification decision.

We encourage you to share this certification decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's certification decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

The Joint Commission

October 17, 2012

Wright Pinson, MBA, MD
Deputy Vice Chancellor for Health Affairs,
CEO
Vanderbilt University Hospital and The
Vanderbilt Clinic
1211 22nd Avenue South
Nashville, TN 37232-2101

Joint Commission ID #: 7892
Program: Behavioral Health Care Accreditation
Accreditation Activity: 60-day Evidence of
Standards Compliance
Accreditation Activity Completed: 10/05/2012

Dear Dr. Pinson:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Behavioral Health Care

This accreditation cycle is effective beginning July 24, 2012. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

The Joint Commission

November 15, 2012

Wright Pinson, MBA, MD
Deputy Vice Chancellor for Health Affairs,
CEO
Vanderbilt University Hospital and The
Vanderbilt Clinic
1211 22nd Avenue South
Nashville, TN 37232-2101

Joint Commission ID #: 7892
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of
Standards Compliance
Accreditation Activity Completed: 11/09/2012

Dear Dr. Pinson:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning July 28, 2012. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

The Joint Commission

November 15, 2012

Re: # 7892
CCN: #440039
Program: Hospital
Accreditation Expiration Date: July 28, 2015

Wright Pinson
Deputy Vice Chancellor for Health Affairs, CEO
Vanderbilt University Hospital and The Vanderbilt Clinic
AA 1204 MCN, 1161 21st Ave. S.
Nashville, Tennessee 37232-2101

Dear Dr. Pinson:

This letter confirms that your July 23, 2012 - July 27, 2012 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on September 28, 2012, October 05, 2012, October 23, 2012 and November 02, 2012 and the successful on-site Medicare Deficiency Follow-up event conducted on September 06, 2012, the areas of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of July 28, 2012. We congratulate you on your effective resolution of these deficiencies.

§482.12 Condition of Participation: Governing Body
§482.41 Condition of Participation: Physical Environment

The Joint Commission is also recommending your organization for continued Medicare certification effective July 28, 2012. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following location(s):

Hemodialysis Clinic East
20 Rachel Drive, Nashville, TN, 37214

Patterson Medical Clinic
1020 South Main Street. Ste B, Franklin, KY, 42134

Sleep Lab
Marriott @ Vanderbilt, 2555 West End Ave, Nashville, TN, 37203

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

The Joint Commission

Vanderbilt at One Hundred Oaks
719 Thompson Lane, Nashville, TN, 37204

Vanderbilt Bone & Joint Surgery Center
225 Bedford Way, Franklin, TN, 37064

Vanderbilt Bone & Joint Clinic
206 Bedford Way, Franklin, TN, 37064

Vanderbilt Brentwood Primary Care Clinic
343 Franklin Road Suite 101, Brentwood, TN, 37027

Vanderbilt Center for Women's Imaging
3319 West End Avenue - Suite 650, Nashville, TN, 37203

Vanderbilt Eye Institute - Lebanon
1670 West Main St., Suite #100, Lebanon, TN, 37087

Vanderbilt Eye Institute - Murfreesboro
1821 Heritage Park Plaza, Murfreesboro, TN, 37129

Vanderbilt Eye Institute at Bellevue
7640 Highway 70 South, Suite 100, Nashville, TN, 37221

Vanderbilt Eye Institute at Franklin
100 Covey Drive, Suite 107, Franklin, TN, 37067

Vanderbilt Franklin Women's Center
4155 Carothers Parkway, Franklin, TN, 37067

Vanderbilt Heart - Pulaski
1265 College St., Suite 2-A, Pulaski, TN, 38478

Vanderbilt Heart at Murfreesboro
1370 Gateway Blvd. Suite 210, Murfreesboro, TN, 37129

Vanderbilt Heart at Williamson Medical Center
4323 Carothers Parkway; 405, Franklin, TN, 37067

Vanderbilt Heart at Winchester
1397 South College Street, Suite 1, Winchester, TN, 37398

Vanderbilt Ingram Cancer Center - Green Hills
3810 Bedford Ave., Suite 100, Nashville, TN, 37215

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

The Joint Commission

Vanderbilt Medical Group - Westhaven
1025 Westhaven Boulevard, Franklin, TN, 37064

Vanderbilt Medical Group at Clarksville
647 Dunlap Lane, Clarksville, TN, 37040

Vanderbilt Medical Group at Columbia
1220 Trotwood Ave., Columbia, TN, 38401

Vanderbilt Medical Group at Coolsprings Blvd.
324 Coolsprings Blvd., Franklin, TN, 37064

Vanderbilt Medical Group at Green Hills
2002 Richards Jones Road Suite B-300, Nashville, TN, 37215

Vanderbilt Medical Group at Green Hills Village Way
3841 Green Hills Village Way, Nashville, TN, 37215

Vanderbilt Medical Group at Lebanon
1420 Baddour Parkway, Lebanon, TN, 37087

Vanderbilt Medical Group at Shelbyville
200 Dover St., Shelbyville, TN, 37160

Vanderbilt Medical Group at Springhill
3098 Campbell Station Parkway, Spring Hill, TN, 37174

Vanderbilt Medical Group at West End Ave.
2611 West End Ave., Nashville, TN, 37203

Vanderbilt Orthopedics - Wilson County
5002 Crossings Circle, Suite 230, Mount Juliet, TN, 37122

Vanderbilt Rheumatology Clinic
2001 Mallory Lane, Suite 100, Franklin, TN, 37067

Vanderbilt Sleep Disorders Center - Franklin
650 Bakers Bridge Avenue, Franklin, TN, 37067

Vanderbilt University Hospital and The Vanderbilt Clinic
1211 21st Avenue South, Nashville, TN, 37232-2101

Vanderbilt Williamson County Clinics at Coolsprings
2009 Mallory Lane, Franklin, TN, 37067

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

The Joint Commission

Vanderbilt Williamson County Clinics at Edward Curd Lane
2105 Edward Curd Lane, Franklin, TN, 37067

Vanderbilt Williamson County Clinics at the Brentwood Shoppe
782 Old Hickory Blvd., Brentwood, TN, 37027

Vanderbilt Williamson County Clinics at the Walk-in
919 Murfreesboro Road, Franklin, TN, 37067

Vanderbilt-Ingram Cancer Center at Northcrest
500 Northcrest Drive, Suite 521, Springfield, TN, 37172

We direct your attention to some important Joint Commission policies. First, your Medicare report is publicly accessible as required by the Joint Commission's agreement with the Centers for Medicare and Medicaid Services. Second, Joint Commission policy requires that you inform us of any changes in the name or ownership of your organization, or health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 4 /Survey and Certification Staff

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

Dozier, Cheryl A

From: Cha, Ellen <ECha@jointcommission.org>
Sent: Monday, September 24, 2012 9:46 AM
To: Conatser, Paige; Hofstetter, Patricia; Dozier, Cheryl A
Subject: Emailing: Report

Good Morning,

Here is the ESC 45.

Thank you,

Vanderbilt University Hospital and The Vanderbilt Clinic

Organization ID: 7892

1211 22nd Avenue SouthNashville, TN 37232-2101

Accreditation Activity - 45-day Evidence of Standards Compliance Form

Due Date: 9/22/2012

HAP Standard EC.02.03.01 The hospital manages fire risks.

Findings: EP 1 Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the building tour it was observed in the elevator penthouse of the Children Hospital, the cover panel was not installed on a high voltage bus power supply and therefore did not minimize the potential for harm from fire and smoke. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the building tour it was observed in the B 405 mechanical room of the VUH building, high voltage wires were exposed in an electrical junction box which did not have a cover plated installed and therefore did not minimize the potential for harm from fire and smoke. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the building tour it was observed in electrical room # 2204 of the VUH building, high voltage wires were exposed in an electrical junction box which did not have a cover plated installed and therefore did not minimize the potential for harm from fire and smoke. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the building tour it was observed on the 1st floor CCT elevator lobby, above the ceiling, high voltage wires were exposed in an electrical box with the cover door opened and therefore did not minimize the potential for harm from fire and smoke.

Elements of Performance:

1. The hospital minimizes the potential for harm from fire, smoke, and other products of combustion.

Scoring Category: CCorrective Action Taken:
WHO:

Assistant Vice Chancellor for Facilities and Construction; Director Operations & Compliance for Medical Center Plant Services

WHAT:

1. Installed cover panel on high voltage bus power supply in elevator penthouse of Children's Hospital. 2. Installed cover plate on open junction box in VUH building mechanical room B405 and electrical room #2204. 3. Installed cover door on open electrical box above ceiling of 1st floor CCT elevator lobby.

WHEN:

7/27/2012

HOW:

1. The Children's Hospital elevator penthouse controller cover was replaced by the elevator service company technician. 2. A work order (#591963) was completed by the Electric Shop staff for the VUH and CCT locations referenced. 3. Reviewed the standardized process for above ceiling permit program. Work was completed by certified staff.

HAP Standard EC.02.03.05 **The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.**

Findings: EP 4 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park,

Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the document review it was observed that at time of survey the hospital did not every 12 months, test all fire alarm devices such as visual alarms, audio alarms and speakers. At time of survey the hospital did not have the visual/audio alarm # 1 located in the VUH generator room listed in the device inventory. At time of survey the hospital did not have documentation of the audio/visual alarm # 1 located in the VUH generator room being tested and inspected every 12 months. At time of survey the hospital did not have documentation of this device being testing in installed or tested in 2010, 2011 or 2012. During the document review the hospital's plant operation director told the life safety surveyor and the team leader surveyor that at time of survey the hospital did not have an accurate inventory of all fire alarm devices. Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the document review it was observed that at time of survey the hospital did not every 12 months, test all fire alarm devices such as visual alarms, audio alarms and speakers. At time of survey the hospital did not have the visual/audio alarm # 2 located in the VUH generator room listed in the device inventory. At time of survey the hospital did not have documentation of the audio/visual alarm # 2 located in the VUH generator room being tested and inspected every 12 months. At time of survey the hospital did not have documentation of this device being testing in installed or tested in 2010, 2011 or 2012. During the document review the hospital's plant operation director told the life safety surveyor and the team leader surveyor that at time of survey the hospital did not have an accurate inventory of all fire alarm devices. Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the document review it was observed that at time of survey the hospital did not every 12 months, test all fire alarm devices such as visual alarms, audio alarms and speakers. At time of survey the hospital did not have the visual/audio alarm located in the VUH room 4148 A listed in the device inventory. At time of survey the hospital did not have documentation of the audio/visual alarm located in the VUH room 4148 A being tested and inspected every 12 months. At time of survey the hospital did not have documentation of this device being in installed or tested in 2010, 2011 or 2012. During the document review the hospital's plant operation director told the life safety surveyor and the team leader surveyor that at time of survey the hospital did not have an accurate inventory of all fire alarm devices. Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the document review it was observed that at time of survey the hospital did not every 12 months, test all fire alarm devices such as visual alarms, audio alarms and speakers. At time of survey the hospital did not have the visual/audio alarm located in the VUH room 4148 B listed in the device inventory. At time of survey the hospital did not have documentation of the audio/visual alarm located in the VUH room 4148 B being tested and inspected every 12 months. At time of survey the hospital did not have documentation of this device being in installed or tested in 2010, 2011 or 2012. During the document review the hospital's plant operation director told the life safety surveyor and the team leader surveyor that at time of survey the hospital did not have an accurate inventory of all fire alarm devices. Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the document review it was observed that at time of survey the hospital did not every 12 months, test all fire alarm devices such as visual alarms, audio alarms and speakers. At time of survey the hospital did not have the visual/audio alarm located in the VUH room 4148 mens/ladies rest room listed in the device inventory. At time of survey the hospital did not have documentation of the audio/visual alarm located in the VUH room 4148 mens/ladies rest room being tested and inspected every 12 months. At time of survey the hospital did not have documentation of this device being in installed or tested in 2010, 2011 or 2012. During the document review the hospital's plant operation director told the life safety surveyor and the team leader surveyor

that at time of survey the hospital did not have an accurate inventory of all fire alarm devices.

Elements of Performance:

4. Every 12 months, the hospital tests visual and audible fire alarms, including speakers. The completion date of the tests is documented. Note: For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2).

Scoring Category: CCorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction,Director Operations & Compliance for Medical Center Plant Services

WHAT:

1. Added audio visual alarm #1 and alarm #2 located in the VUH generator room, VUH Room 4148A, VUH Room 4148B, and VUH Room 4148 Men's/Ladies Restroom into the device inventory. 2. Added the identified devices to the Preventive Maintenance (PM) System and performed PM on the devices. 3. Verified inventory of all audio visual alarm devices located VUH Generator Room. 4. Conducted audit of inventory of audio visual alarms for accuracy by consultant. 5. Developed standard operating process "VUMC policy for Modifications to any VUMC Fire Alarm System" to assure inventory accuracy.

WHEN:

8/1/12 added audio alarm #1 and #2 in cited areas 8/1/12 verified inventory of all audio visual alarm devices located in VUH Generator Room 8/4/12 added identified devices to the PM System and performed PM on devices 9/20/12 completed inventory of audio visual alarms 9/20/12 developed SOP

HOW:

1 & 2. Missing inventory items were field verified for location and device information and accurately entered into microprocessor based work management system with associated PM performed under Work Order 376339. 3. The devices were scheduled for their annual PM check. Process established to audit PM record compliance of audio visual alarm devices. 4. Vanderbilt employed a third party to perform a room by room inventory of observed Life Safety Equipment. That information was compared to the existing inventory database with any missing items added. 5. Established process for periodic random sampling by 3rd party to verify inventory accuracy.

HAP Standard EC.02.05.05 The hospital inspects, tests, and maintains utility systems. Note: At times, maintenance is performed by an external service. In these cases, hospitals are not required to possess maintenance documentation but must have access to such documentation during survey and as needed.

Findings: EP 3 Â§482.41(a) - (A-0701) - Â§482.41(a) Standard: Buildings The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This Standard is NOT MET as evidenced by: Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the document review it was observed that the hospital did not test and maintain the medical gas system. The hospital's plant operations director informed the life safety surveyor and the team leader surveyor that the hospital conducts all inspection and maintenance actives in house with the exception of the medical gas master alarm panels, and uses the manufactures inspection and maintenance recommendations for the medical gas system components. . At time of survey the hospital did not have the manufactures recommendations for inspections and testing of any of the medical gas system components, and therefore the testing and maintenance activities could not be verified at time of survey. At time of survey the hospital also did not have the vendor's inspection and maintenance documentation of the alarms on the medical gas master alarm panels and at time of survey the testing and maintenance of the alarms on the medical gas master alarm panels also could not be verified.

Elements of Performance:

3. The hospital inspects, tests, and maintains the following: Life-support utility system components on the inventory. These activities are documented. (See also EC.02.05.01, EPs 2-4)

Scoring Category: ACorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction,Director Operations & Compliance for Medical Center Plant Services

WHAT:

1. Reviewed recommended maintenance activities from original equipment manufacturers. 2. Confirmed PM documentation is current and accurate. 3. Engaged a third party to evaluate the operations and maintenance of the medical gas system.

WHEN:

9/20/12

HOW:

1. Plant Services verified that the Operations and Maintenance manuals, testing and inspection documentation for alarm panels, zone valves, MG outlets, etc. were in place and current. 2. VUMC employed third party to verify the inventory of all MG components and develop updated facility drawings of the medical gas distribution system. 3. Engaged a third party to evaluate the operations and maintenance of the medical gas system. 4. Established a process for unannounced quarterly review by third party consultant to provide on-going verification of processes and procedures.

HAP	**Standard EC.02.05.07**	**The hospital inspects, tests, and maintains emergency power systems. Note: This standard does not require hospitals to have the types of emergency power equipment discussed below. However, if these types of equipment exist within the building, then the following maintenance, testing, and inspection requirements apply.**

Findings: EP 5 Â§482.41(a) - (A-0701) - Â§482.41(a) Standard: Buildings The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This Standard is NOT MET as evidenced by: Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the document review it was observed that the PHV generator did not meet either the 30% of nameplate rating or the recommended exhaust gas temperature during all test in EC.02.05.07, EP 4 . It was observed that the hospital did not conduct a load bank test on the PHV generator every 12 months. The load bank test was conducted on April 4, 2011 and not again until June 15, 2012. EP 6 Â§482.41(a) - (A-0701) - Â§482.41(a) Standard: Buildings The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This Standard is NOT MET as evidenced by: Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the document review it was observed that the hospital did not document twelve times a year, at intervals of not less than 20 days and not more than 40 days, the testing of all automatic transfer switches. Transfer switches 0201, 1000, 1001, and 1002 were documented as being tested on Nov. 3, 2011 and not again until Jan 5, 2012.

Elements of Performance:

5. The emergency generator tests are conducted with a dynamic load that is at least 30% of the nameplate rating of the generator or meets the manufacturerâ€™s recommended prime moversâ€™ exhaust gas temperature. If the hospital does not meet either the 30% of nameplate rating or the recommended exhaust gas temperature during any test in EC.02.05.07, EP 4, then it must test each emergency generator once every 12 months using supplemental (dynamic or static) loads of 25% of nameplate rating for 30 minutes, followed by 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 2 continuous hours.

Scoring Category: ACorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction,Director Utilities and Construction for Medical Center Plant Services

WHAT:

Modified PM process for this particular generator test.

WHEN:

8/10/2012

HOW:

1. The preventive maintenance procedure for the load bank testing of the PHV generator was modified to provide a unique preventive maintenance task for the load bank test that includes the appropriate specifications. The new

PM task description lists the TJC standard number and the testing requirements. 2. Process established for review of the annual Preventive Maintenance records to verify compliance with standard and standardized testing procedure.

6. Twelve times a year, at intervals of not less than 20 days and not more than 40 days, the hospital tests all automatic transfer switches. The completion date of the tests is documented.

Scoring Category: ACorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction; Director Utilities and Construction for Medical Center Plant Services

WHAT:

1. Staff who performed the PM activity in question verified that the ATS equipment was properly tested. 2.Generator load records for December 2011 verified that the ATS equipment had been exercised. 3. Reviewed a comprehensive 12 month history of these maintenance activities to verify that individual equipment check off wasn't required and was performed consistently. 4. In May of 2012, Medical Center Plant Services Preventative Maintenance Policy #15, was revised to improve our documentation process.

WHEN:

8/10/12

HOW:

1. Plant Services Electric Shop staff was interviewed about the December 2011 ATS testing to verify that the testing took place per the maintenance tasks on the PM ticket. The staff member who did the testing signed an attestation that the ATS testing was compliant. 2. Generator load testing was reviewed to verify that the ATS equipment had been properly tested. Load test data shows conclusively that all the ATS equipment had been tested. 3. Established process for review of monthly preventive maintenance records on a monthly basis to verify compliance with standard testing requirements. 4. Plant Services revised its Medical Center Plant Services Preventative Maintenance Policy #15 to require "check boxes" be used to document completion of each task on the PM Work Order. Prior policy did not require each box to be individually checked.

HAP Standard EC.02.05.09 **The hospital inspects, tests, and maintains medical gas and vacuum systems. Note: This standard does not require hospitals to have the medical gas and vacuum systems discussed below. However, if a hospital has these types of systems, then the following inspection, testing, and maintenance requirements**

Findings: EP 1 Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the document review it was observed that the hospital did not test, inspect and maintain the medical gas system in time frames defined by the hospital. During the document review it was observed that the hospital did not have documentation of any of the alarms on any Medical Gas Master Alarm panels being tested and inspected and maintained. The hospital informed the life safety surveyor and the team leader surveyor that the testing and inspection of the Medical Gas Master alarms were conducted by the manufacture and at time of survey the hospital did not have any documentation of the alarms on the Master Alarm Panels being tested and maintained. The master alarms panels were not on the utilities equipment inventory. At time of survey the plant operation director told the life safety survey and the team leader surveyor that the testing and inspection of the medical gas system for the last 2 inspection were only 65 % complete. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the building tour, document review and staff discussion it was observed that the hospital did not maintain the medical gas system. It was observed that at time of survey the audio alarm on the medical gas area alarm panel located on the 4th floor NICU of the VUH was not working properly and a low oxygen alarm light and read out was showing on the panel. At time of survey the nurse manager and other staff on the unit was not aware of the alarm. The plant operations director informed the life safety surveyor and the team leader surveyor that the special equipment repair shop identified that this panel was not working properly on May 10, 2012. At time of survey the hospital received a quote from the vendor to replace the panel. EP 3 Observed in Tracer Activities at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During tracer activity in the Oral Surgery Clinic, it was observed that the area shutoff valve for piped medical gas did not identify what the valve controlled. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the building tour it was observed that the medical gas zone shut off valve located outside the kitchen in the Children Hospital was not properly labeled. During the building tour it was observed that the medical gas zone shut off valve located in the PACU of the VUH was not properly labeled.

Elements of Performance:

1. In time frames defined by the hospital, the hospital inspects, tests, and maintains critical components of piped medical gas systems, including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors, and outlets. These activities are documented. (See also EC.02.05.01, EP 3)

Scoring Category: ACorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction; Director Operations & Compliance for Medical Center Plant Services

WHAT:

The response below address both observations: 1. Master medical gas alarm panels were located in the existing preventive maintenance equipment inventory. Master medical gas alarm panels have a detailed preventive maintenance history documented. Reviewed recommended master alarm panel maintenance activities from original

equipment manufacturers and confirmed PM documentation is current and accurate. 2.Communicated with clinical staff that medical gas area alarm panel on the 4th floor VUH NICU was not working properly. 3. Scheduled and replaced 4th floor VUH NICU panel. 4. Engaged a third party to evaluate the entire medical gas system to include inspection, testing and maintenance activities. 5. Developed Policy SA 10-10.05 Life Safety Systems Area Medical Gas Alarm Panels.

WHEN:

7/25/12 communicated medical gas alarm panel not working properly 7/28/12 scheduled and replaced 4th floor VUH NICU medical gas panel 7/30/2012 located Master medical gas alarm panel on existing inventory 8/3/12 confirmed PM documentation is current and accurate 8/20/12 Developed Policy SA 10-10.05 Life Safety Systems Area Medical Gas Alarm Panels 8/23/12 3rd party evaluated entire medical gas system

HOW:

The response below address both observations: 1.Plant Services verified that the Operations and Maintenance manuals, testing and inspection documentation for medical gas master alarm panels were in place and current. Master medical gas alarm panels were located in the existing preventive maintenance equipment inventory and their associated item descriptions were clarified. Master medical gas alarm panels had an existing detailed preventive maintenance history documented. 2. Posted notification signs and verbally communicated to the clinical staff, face to face, the status of the medical gas area alarm panel in the VUH NICU. 3. The panel was replaced and the new panel recertified immediately after it was installed. 4. Engaged third party to evaluate the operation and inspection, testing and maintenance of the medical gas system. 5. Established a process for unannounced quarterly review by third party consultant to provide on-going verification of processes and procedures. 6. Developed, approved, and implemented Policy SA 10-10.05 Life Safety Systems-Area Medical Gas Alarm Panels; this policy addresses communication process to clinical staff.

3. The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control.

Scoring Category: ACorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction; Director Operations & Compliance for Medical Center Plant Services

WHAT:

Properly labeled referenced medical gas shutoff valves.

WHEN:

7/27/2012

HOW:

A Work Order was generated in the Plant Services work management system and assigned to Plumbing Shop staff who labeled the referenced medical gas shutoff valves.

HAP Standard HR.01.06.01 Staff are competent to perform their responsibilities.

Findings: EP 15 Observed in HR File Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. Documentation in HR record for a facility management (SER) employee revealed a "Job Skill Assessment" dated 7/14/2010 stating the employee "needs training" under the topics of resetting Honeywell Fire System; resetting Simplex Fire System; and medical gas. The employee was certified as a Level 1 alarm technician in January 2011. There was no evidence of documentation for action taken for education/training and re-evaluation of competence for these areas July 2010 through January 2011.

Elements of Performance:

15. The hospital takes action when a staff memberâ€™s competence does not meet expectations.

Scoring Category: ACorrective Action Taken:

WHO:

Responsible for the approved corrective action and ongoing compliance or procedure - Directors of Plant Services; Assistant Vice Chancellor for Facilities and Construction, Manager of Human Resources Training - HR manager

WHAT:

Plant Services leadership re-educated to the required contents for employee files, and documentation of actions taken for education/training and re-evaluation of competence. Audit completed of employee files to verify SER annual job skill assessments were completed for 2012 including the specific employee observed in this finding. The additional training identified in the observation was completed and documentation was placed in the employee file. Plant Services managers enhanced the documentation of new SER employees competency through an end of probation checklist completed by the supervisor.

WHEN:

-August 8, 2012 Plant Services leadership training occurred. -August 23, 2012 employee files were audited and verified to include 2012 skills assessments. -August 29, 2012 Plant Services created end of probation competency checklist.

HOW:

HR manager conducted training during a meeting with Plant Services Department leadership to review required content for employee files and competency documentation. Plant Services Department leadership created and implemented end of probation competency checklist to be used through observation or direct interaction for Plant Services staff. Plant Services leadership established a process to conduct annual skills training and document annual ongoing competency using a skills assessment document for Plant Services staff.

HAP Standard LS.01.01.01 The hospital designs and manages the physical environment to comply with the Life Safety Code.

Findings: EP 2 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour it was observed that at time of survey the hospital did not have an accurate set of Life Safety Code drawing for the VUH building. It was observed in the basement mechanical room of the VUH building, the life safety drawing identified a fire door at the exit stair that had been removed. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour it was observed that at time of survey the hospital did not have an accurate set of Life Safety Code drawing for the VUH building. The life safety drawings identified a fire door located on the 1st floor near room 1302 and the fire door had been removed. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour it was observed that at time of survey the hospital did not have an accurate set of Life Safety Code drawing for the VUH building. The life safety drawings identified a fire wall in the 2nd floor mechanical room with no door. A door was installed in the fire wall and the door fire rating could not be verified.

Elements of Performance:

2. The hospital maintains a current electronic Statement of Conditions (E-SOC). Note: The E-SOC is available to each hospital through The Joint Commission Connectâ„¢ extranet site.

Scoring Category: ACorrective Action Taken: 123

WHO:

Assistant Vice Chancellor for Facilities and Construction; Director Operations & Compliance for Medical Center Plant Services

WHAT:

1.Ordered and installed replacement fire doors for the basement mechanical room exit stair and 2nd floor mechanical room locations referenced. 2.Investigated history of door frame on the 1st floor near room 1302 and determined the Life Safety Code drawings were incorrect. Accordingly, revised the Life Safety Code drawings to reflect the correct condition.

WHEN:

8/8/12 installed replacement doors in cited areas 8/18/12 revised Life Safety Code drawings to reflect the corrected condition

HOW:

1. A work order was generated in the Plant Services work management system and assigned to Carpentry Shop staff who installed new fire rated doors for the basement and 2nd floor locations referenced. 2. The construction project punch list process will be used to verify missing doors are identified and installed. 3. Hospital engaged a 3rd party who reviewed and produced a new set of Life Safety Drawings. For future projects, a process was established to review the final documents with construction personnel and Plant Services personnel to verify Life Safety Drawings are accurately reflected. The deliverables required by the architect will include an updated life safety drawing.

HAP Standard LS.01.02.01 The hospital protects occupants during periods when the Life Safety Code is not met or during periods of construction.

Findings: EP 2 Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the building tour of the Medical Center North building, it was observed on the 6th floor that an exit was removed and a temporary wall was installed due to the S 6400 renovation project and at time of survey there was not signage identifying the location of alternative exits to everyone affected. Observed in Individual Tracer at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During an individual patient tracer in the Children's Hospital in the GI Lab area, it was observed that there was a temporary wall in place and the egress signage still indicated that this had been an exit. There were no alternative signage observed.

Elements of Performance:

2. The hospital posts signage identifying the location of alternative exits to everyone affected. (See also LS.01.01.01, EP 3)

Scoring Category: ACorrective Action Taken: 124

WHO:

Assistant Vice Chancellor for Facilities and Construction; Director Operations & Compliance for Medical Center Plant Services; Construction Coordinator

WHAT:

For both the Medical Center North and Children's Hospital locations referenced, installed exit signs and signage identifying the location of alternate exits for associated areas.

WHEN:

7/27/2012

HOW:

1.A Work Order was generated in the Plant Services work management system and assigned to the Electric Shop staff who installed additional Exit signs. 2. The Construction Coordinator installed signage identifying the location and route to alternate exits. 3. The Construction Coordinator conducts Risk Assessments and identifies egress requirements.

HAP Standard NPSG.01.01.01 Use at least two patient identifiers when providing care, treatment, and services.

Findings: EP 2 Observed in Tracer Activities at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During tracer activity in the Dialysis clinic, it was noted that blood specimen containers were being labeled prior to the patient's receiving care. Individual bags of pre-labeled blood collection tubes were available on the counter. Observed in Tracer Activities at Hemodialysis Clinic East (20 Rachel Drive, Nashville, TN) site. During tracer activity in the Dialysis clinic, it was noted that blood specimen containers were being labeled prior to the patient's receiving care. Individual bags of pre-labeled blood collection tubes were located in a basket on the counter.

Elements of Performance:

2. Label containers used for blood and other specimens in the presence of the patient. (See also NPSG.01.03.01, EP 1)

Scoring Category: ACorrective Action Taken:

WHO:

Responsible for the corrective action and ongoing compliance: Associate VMG Director, Clinical Manager. Responsible for approved action or procedure: Associate VMG Director, Area Manager.

WHAT:

The pre-labeling process was immediately changed by the Clinical Managers of the VAV Dialysis Clinic and

Hemodialysis Clinic East, via informal clinical staff training. Formal training completed with emphasis on patient identification and labeling, VUMC processes for collecting blood specimens, and Policy CL 30-08.22 "Labeling of Laboratory Specimens": "Containers used for blood and other specimens are labeled in the presence of the patient."

WHEN:

July 26 and 27, 2012: Immediate training and process change completed. August 21, 2012: Formal training completed in the Village at Vanderbilt Dialysis Clinic: and the Hemodialysis Clinic East.

HOW:

The Clinic Manager immediately discarded all pre-labeled blood collection tubes and verbally instructed staff on the process change. An educational presentation regarding the current policy CL 30-08.22 "Labeling Laboratory Specimens" was presented and distributed to the dialysis clinical staff for review.

HAP Standard NPSG.03.04.01 **Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings. Note: Medication containers include syringes, medicine cups, and basins.**

Findings: EP 2 Observed in Tracer Activities at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During tracer activity at the Plastics clinic a procedure room was made ready for excision and closure of facial lesions. The mayo stand had been prepared with the sterile instruments and the small empty metal cups and empty syringe were found labeled. The patient had not yet arrived for the procedure. A review of the hospital policy revealed, "Label medication container/storage device when any medication in transferred from the original packaging to another container/storage device and is not immediately administered." Observed in Individual Tracer at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During an individual patient tracer in the Children's Hospital operating room, it was observed that the sterile field had a basin with a label, but there had not been any transfer of fluids or medications. The organizational policy, CI30-06-21, requires that the label would be completed at the time of transfer if not immediately administered.

Elements of Performance:

2. In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.

Scoring Category: ACorrective Action Taken:

WHO:

Responsible for the corrective action and ongoing compliance: Administrative Director, Clinical Managers. Responsible for approved action or procedure:

Administrative Director.

WHAT:

Clinical staff were educated on VUMC process and policy CL 30-06.21 "Medication Labeling: Outside of Pharmacy." Policy states "Label medication/solution package/container/ storage device when any medication is transferred from the original packaging to another package/ container/storage device and is not immediately administered. Label medication/solution package/ container/storage device as soon as it is prepared, unless it is immediately administered."

WHEN:

August 17, 2012: Plastic Surgery Clinic staff training completed. July 31, 2012 and August 13, 2012: Children's Operating Room staff training completed.

HOW:

Inservice training were completed, an educational memo regarding the current policy CL 30-06.21 "Medication Labeling: Outside of Pharmacy" was electronically distributed to the clinical staff.

HAP Standard PC.01.02.07 The hospital assesses and manages the patient's pain.

Findings: EP 3 Observed in Individual Tracer at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. The post operative patient reported on July 25 a pain level of 8 at 01:20, a pain level of 7 at 04:05, and a pain level of 8 at 07:49. The patient was medicated at each of those times. There was no documentation of interventions and the effectiveness of them between 01:20 and 04:05 and 07:49. A physician order for an additional medication for pain was obtained at 06:00. Observed in Individual Tracer at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. On July 23 patient was medicated for pain level of five .The next assessment of response to the pain management intervention was at 3:30 on July 24,and pain level was five.There was no documentation of further interventions or the effectiveness of pain management between 17:30, July 23 and 3:30, July 24 ,2012.

Elements of Performance:

3. The hospital reassesses and responds to the patientâ€™s pain, based on its reassessment criteria.

Scoring Category: CCorrective Action Taken:

WHO:

Responsible for the corrective action and ongoing compliance: Nurse Managers of 8N and 7T3; Administrative Director for Medicine and Administrative Director for Surgery/Burn; Chief Nursing Officer VUH. Responsible for approved action or procedure: Nurse Managers of VUH 7T3 and Manager of VUH 8th floor; Administrative Director for Medicine and Administrator

Director for Surgery/Burn; Chief Nursing Officer VUH.
Training:All RNs on VUH 7T3 and VUH 8 North.
Responsible for Measure of Success: Nurse Managers of VUH 7T3 and Manager of VUH 8N; Administrative Director for Medicine and Administrator Director for Surgery/Burn.

WHAT:

Applicable clinical staff were educated on VUMC process and policy CL 30-02.04 "Pain Management Guidelines" section V.A.3. The policy states "In Inpatient areas, document the following with date and time:Reassessment of pain response to interventions is documented at an interval based on patient condition and type and route of pharmacologic intervention."

WHEN:

8/23/12: Corrective action plan presented to the Vanderbilt University Hospital Nursing Leadership Board.
9/20/2012: training completed.

HOW:

Electronic learning module developed and assigned to clinical staff on 8N and 7T3.

Evaluation Method:	Medical record review is the selected method to evaluate the effectiveness of the corrective actions. A computer generated random sample of 70 random patient medical records with pain from units 7T3 and 8N will be reviewed monthly for reassessment of pain after medication. Title of person collecting data: Nurse manager and Administrative director of the two units. Numerator= # of reassessment after pain medication Denominator= # of pain medications administered to 70 patients with pain Frequency = Monthly Duration 4 consecutive months
Measure of Success Goal (%):	90

Dozier, Cheryl A

From: Cha, Ellen <ECha@jointcommission.org>
Sent: Wednesday, September 26, 2012 2:04 PM
To: Conatser, Paige; Hofstetter, Patricia; Dozier, Cheryl A
Subject: Emailing: Report

Vanderbilt University Hospital and The Vanderbilt Clinic

Organization ID: 7892

1211 22nd Avenue SouthNashville, TN 37232-2101

Accreditation Activity - 60-day Evidence of Standards Compliance Form

Due Date: 10/7/2012

BHC	**Standard CTS.02.01.05**	**For organizations providing care, treatment, or services in nonâ€"24-hour settings: The organization implements a written process requiring a physical health screening to determine the individual's need for a medical history and physical examination. Note 1: This standard does not apply to foster care and therapeutic foster care. (See also CTS.02.04.01, EP 1) Note 2: This standard does not apply to organizations that provide physical examinations to all individuals served as a matter of policy or to comply with law and regulation.**

Findings: EP 1 Observed in Individual Tracer at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. The organization has implemented a health screening process. However, in reviewing that process, and in reviewing policy and procedure, they have not established screening triggers that indicate the need for a medical history and physical examination.

Elements of Performance:

1. For organizations providing care, treatment, or services in nonâ€"24-hour settings: The organization has a written physical health screening process to determine whether an individual served is in need of a medical history and physical examination that is based on the population(s) served and, at a minimum, includes the following: - Data to be collected - Time frame for completion of the screening - Screening triggers that indicate the need for a medical history and physical examination

Scoring Category: ACorrective Action Taken:

WHO:

Director of Social Work and Partial Hospitalization Program (PHP); Chief Medical Officer (PHP) Trained: PHP staff

WHAT:

1.Health Screening revised. 2.Staff educated. 3.The revised tool was implemented.

WHEN:

September 1, 2012: Staff educated and health screening tool implemented.

HOW:

1. Health Screening revised in collaboration with the Chief Medical Officer for the addition of triggers that indicate a need for a Physical Examination. 2. Staff educated on the revised tool at staff meeting. 3. The revised tool was implemented.

BHC Standard CTS.03.01.03 The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

Findings: EP 3 Observed in Individual Tracer at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. The current treatment plan format included a goal and interventions but did not have objectives. Objectives for each goal should be developed and should be expressed in terms that provide indices of progress. Observed in Individual Tracer at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. The current treatment plan format did not include objectives. Observed in Individual Tracer at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. The current treatment plan format did not include objectives.

Elements of Performance:

3. The objectives of the plan for care, treatment, or services meet the following criteria: - They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3) - They are sufficiently specific to assess the progress of the individual served - They are expressed in terms that provide indices of progress

Scoring Category: CCorrective Action Taken:

WHO:

Director of Social Work and Partial Hospitalization Program (PHP) Trained: Staff (PHP)

WHAT:

"Objectives" added to the treatment plan and staff educated.

WHEN:

August 23, 2012: All PHP staff trained. September 1, 2012: Revised treatment plan was implemented.

HOW:

August 23, 2012: Staff trained at staff meeting to quantify objectives on the treatment plan. September 1, 2012: The revised treatment plan was implemented.

Evaluation Method: All patient treatment plans audited for evidence of compliance monthly for four consecutive months. Audit patient treatment plans

objectives for evidence of compliance.
Numerator= # correct treatment plans
Denominator = total number of treatment plans

Measure of Success Goal (%): 90

HAP Standard EC.02.05.01 The hospital manages risks associated with its utility systems.

Findings: EP 1 Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the document review , building tour and staff discussion it was observed that the hospital did not design and install utility systems that meet patient care and operational needs. It was observed during the building tour, that a field fire alarm panel located in a mechanical room on the 4th floor of the VUH was in alarm, and at the front head end master fire alarm computer no alarm was identified. The plant operations director informed the life safety surveyor and the team leader due to the age of the fire alarm panels and the additions and modifications of the fire alarm system that the front head end master fire alarm computer can clear an alarm but a technician must physically go to the field fire alarm panel to clear the alarm from that panel. Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the document review , building tour and staff discussion it was observed that the hospital did not design and install utility systems that meet patient care and operational needs. It was observed during the building tour, that a field fire alarm panel located in the delta center has 6 fire alarm light in alarm, and at the front head end master fire alarm computer shows these alarms as 46 troubles. The plant operations director informed the life safety surveyor and the team leader due to the age of the fire alarm panels and the additions and modifications of the fire alarm system that the front head end master fire alarm panel identifies these as troubles. At time of survey the hospital could not identify which of the 46 troubles were associated with the 6 alarms on the field panel. EP 4 Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the document review it was observed that the hospital did not identify, in writing, inspection and maintenance activities for all operating components of utility systems on the inventory. The hospital's plant operations director informed the life safety surveyor and the team leader surveyor that the hospital uses the manufactures inspection and maintenance recommendations on all operating components of the utilities system listed in their equipment inventory. At time of survey the hospital did not have the manufacture written recommendations for the inspection and maintenance of all operating components of the utilities system listed in their equipment inventory. At time of survey the hospital did not have the manufactures recommendations for inspections and testing of any of the air handler unit, domestic hot water pumps, generator fuel pumps, air compressors or any of the medical gas system components. EP 8 Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the building tour of the VUH it was observed that the hospital did not label the following utility system controls to facilitate partial or complete emergency shutdowns: Generator fuel pumps # 1 and # 2 located in the generator mechanical room; the air compressor located in the generator room; Generators 1 though 5; Hot water primary pump # 1 and back up pump # 2 located in mechanical room B405; AHU 11; AHU 12; AHU 14; AHU 22.

Elements of Performance:

1. The hospital designs and installs utility systems that meet patient care and operational needs. (See also EC.02.06.05, EP 1)

Scoring Category: ACorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction: Director of Operations & Compliance for Medical Center Plant Services

WHAT:

1. Reviewed Honeywell documentation of features requiring manual acknowledgment of each alarm at the local panel. 2. Acknowledging all alarm conditions on the field fire alarm panels as they occur 3. Reviewed Honeywell's letter to verify alarm panel requirements. 4. Honeywell reprogrammed panels to accept return to normal acknowledgment from the front end system.

WHEN:

8/3/12: reviewed Honeywell documentation 8/3/2012: process established to acknowledge alarms 8/4/2012: Reviewed Honeywell letter 9/28/2012: reprogrammed panels

HOW:

1. Established a process to acknowledge all alarm conditions on the field fire alarm panels as they occur. 2. Honeywell reprogrammed panels to accept pt return to normal acknowledgment from the front end system.

4. The hospital identifies, in writing, the intervals for inspecting, testing, and maintaining all operating components of the utility systems on the inventory, based on criteria such as manufacturers' recommendations, risk levels, or hospital experience. (See also EC.02.05.05, EPs 3-5)

Scoring Category: ACorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction: Director of Operations & Compliance for Medical Center Plant Services

WHAT:

1. Located and reviewed the Operation & Maintenance (O&M) manuals from original equipment manufacturers for referenced equipment. 2. Confirmed PM documentation is current and accurate.

WHEN:

8/27/2012

HOW:

1. Plant Services verified that the Operations and Maintenance manuals, testing and inspection documentation for air handler units, domestic hot water pumps, generator fuel pumps, air compressors and all medical gas system components were in place and current. 2. Confirmed work management system

inspection and testing PM documentation is current and accurate for all referenced equipment.

8. The hospital labels utility system controls to facilitate partial or complete emergency shutdowns.

Scoring Category: ACorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction: Director of Operations & Compliance for Medical Center Plant Services

WHAT:

Need to address labeling of these items to facilitate shutdown. 1. Developed Shutdown procedures and labeled controls as appropriate.

WHEN:

8/27/2012

HOW:

(Need to address labeling of these items to facilitate shutdown.) 1. The Plant Services Team met with VUMC senior leadership, wrote and implemented shutdown procedures and labeled controls as appropriate. 2. Plant Services staff was trained on steps to apply the Shutdown procedure

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HAP Standard EC.03.01.01 Staff and licensed independent practitioners are familiar with their roles and responsibilities relative to the environment of care.

Findings: EP 2 Â§482.41(b)(7) - (A-0714) - (7) The hospital must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel and guests; evacuation; and cooperation with fire fighting authorities. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Children hospital it was observed the staff working in the Subway restaurant could not describe or demonstrate actions to take in the event of an environment of care incident. The manager of the Subway restaurant said neither her or her staff had been educated to the hospitals safety programs including fire safety. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Children hospital it was observed the staff working in the Taco Bell / Pizza Hut restaurant could not describe or demonstrate actions to take in the event of an environment of care incident. The manager of the Taco Bell/ Pizza Hut restaurant said neither her or her staff have been educated to the hospitals safety programs including fire safety. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour it was observed in the emergency room fast track area that the charge nurse and the manager of the unit did not know where the medical gas zone shut off valves were and could not find them for the fast track rooms 1343A and 1343B. In the event of a fire the hospital policy states that the charge nurse is responsible for shutting off the medical gases.

Elements of Performance:

2. Staff and licensed independent practitioners can describe or demonstrate actions to take in the event of an environment of care incident. (See also EC.02.03.01, EP 10 and HR.01.04.01, EP 1)

Scoring Category: CCorrective Action Taken:

WHO:

Director, Retail VUMC, Patient Transportation Support Services Administration; Director of Environmental Health and Safety; Asst. Director/ Vanderbilt Environmental Health and Safety Who was trained: staff of the identified vendors; charge nurses and the manager of the ED Responsible for Measurement: The Asst. Director Vanderbilt Environmental Health and Safety

WHAT:

1.Developed and Implemented an enhanced safety education plan to include the process to follow in fire safety and emergency prepareness incident for the identified vendor employees in the vendor areas of the hospital. Education includes onboarding vendors and vendor new hires through VUMC new staff orientation. 2. Developed and implemented policy SA 10-10.05 Life Safety Systems â€" Area Medical Gas Alarm Panels. 3. Developed and implemented an enhanced safety education plan for managers and charge nurses regarding medical gas processes to follow in the event of an environment of care incident. 4. Modified annual safety training to include medical gas safety components.

WHEN:

8/9/12: vendor education plan 8/20/12: policy approved/implemented 8/22/12: Staff education plan for medical gases

HOW:

1. Designed a vendor education plan to train identified vendor employees in the steps needed to take in the event of a fire safety and emergency prepareness incident. The Environment of Care Safety module was deployed to identified vendor employees; instruction was lead by the unit leader. Education includes onboarding vendors and vendor new hires through VUMC new staff orientation. 2.The Medical Gas Alarm Panel Policy was developed by VUMC senior leaders and Plant Services; approved by the Medical Center Medical Board. 3. Designed a staff education plan to train managers and charge nurses in the ED Fast Track regarding medical gases and the steps needed to take in the event of an environment of care incident for patient and staff safety. The Medical Gas module was distributed electronically to identified managers, area supervisors and charge nurses. 4. Annual Safety training is electronically accessed by staff.

Evaluation Method: There will be monthly monitoring for 4 consecutive months of the identified random

vendor employees fire safety and emergency prepareness knowledge ; Numerator: compliant vendor employees. Denominator: 30 identified vendor employees. There will be monthly monitoring for 4 consecutive months of ED Charge nurses and manager for medical gas panel knowledge. Numerator: compliant ED Charge nurses and managers. Denominator: all ED charge nurses and managers. The Survey results will be shared with VUMC Leadership monthly.

Measure of Success Goal (%): 90

HAP Standard LD.01.03.01 The governing body is ultimately accountable for the safety and quality of care, treatment, and services.

Findings: EP 2 Â§482.12 - (A-0043) - Â§482.12 Condition of Participation: Condition of Participation: Governing Body This Condition is NOT MET as evidenced by: Observed in Data Tracer at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. The Governing Body did not insure that the following COPs were met as determined by observation, documentation, and staff interviews. COP 482.41 Tag A-0700, Physical Environment system and notifications.

Elements of Performance:

2. The governing body provides for organization management and planning.

Scoring Category: ACorrective Action Taken:

WHO:

Chief Executive Office of Clinical Enterprise and Deputy Vice Chancellor for Health Affairs; Chief Quality and Patient Safety Officer Trained: Identified Vendor staff and identified area staff where medical gas alarm panel are located

WHAT:

1. Annual Life Safety reports and periodic updates are provided to the Medical Center Medical Board and the Governing body through established reporting structures. In addition to the established reporting structure and processes, the Chief Executive Officer of the Clinical Enterprise and Deputy Vice Chancellor for Health Affairs has expanded the reporting and accountability for the Assistant Vice Chancellor of Facilities and Construction to include direct reporting to Deputy Vice Chancellor for Health Affairs. 2. Quarterly reports are made to the Quality Steering Committee of the Vanderbilt University Medical

Center. The Quality Steering Committee, co-chaired by the Chief Executive Officer of the Clinical Enterprise and Vice Chancellor for Health Affairs and the Chief Quality and Patient Safety Officer, has the authority and responsibility to execute recommendations from the Life Safety reports. 3. The VUMC Safety Committee monthly meeting standing reports have been expanded to include additional aspects of life safety. Distributions of meeting minutes have been expanded to include senior leadership. The Environment of Care survey process has been expanded to include additional aspects of Life Safety in their ongoing rounding and audits. 4.Developed and implemented fire safety and emergency preparedness education plan for identified vendor staff. Developed and implemented an enhanced safety education plan for identified staff where medical gas alarm panels are located. 5. Policy SA 10-10.05 Life Safety Systems â€" Area Medical Gas Alarm Panels was approved by the Medical Center Medical Board and approved by senior leadership.

WHEN:

8/ 9/2012: Incorporated new/revised indicators into the Environment of Care(EOC)survey process 8/ 9/2012: Process established for EOC quarterly reports to senior leadership 8/ 15/2012: Most recent enhancements to the accountability structure 8/20/2012: Policy approved

HOW:

1. The changes in the reporting and accountability structure and quarterly Life Safety reports are incorporated into the organizational Quality Improvement work plan and the changes were fully vetted by the senior leadership team and agreed upon. 2. Senior leadership met to review the EOC process. Additional indicators were added and revised in response to the survey findings. 3. Quarterly and annual EOC summary reports continue to be reviewed by the EOC survey team and the Medical Center Safety Committee. Additionally,a process was established for EOC summary reports to be sent directly to senior leadership in the clinical enterprise. 4. The standing life safety reports to the VUMC Safety Committee includes status of required generator testing, automatic transfer switches, Fire Alarm equipment, changes to Life Safety Drawings, and penetrations. 5. A process was established for the EOC team leader to make quarterly reports to the VUH, VCH, VMG and VPH senior leadership cabinet meetings for follow-up actions. 6. The Plant Services Team met with VUMC senior leadership to design a staff education plan to train staff in areas where medical gases exist in the steps needed to take in the event of an environment of care incident. A vendor education plan was designed to train the identified vendor employees in fire safety and emergency preparedness. The plan included a design and deployment of Fire Safety and Emergency Preparedness Safety Training and a design and deployment of a staff electronic E-Learning module focused on the Medical Gases. The Emergency

preparedness vendor safety module was deployed to the identified vendor employees; instruction was led by the unit leader. The Medical Gas module was distributed electronically to VUMC managers, area supervisors and charge nurses of the identified area. 7. The Policy SA 10-10.05 Life Safety Systems â€" Area Medical Gas Alarm Panels was approved by the Medical Center Medical Board.

HAP Standard LD.03.04.01 **The hospital communicates information related to safety and quality to those who need it, including staff, licensed independent practitioners, patients, families, and external interested parties.**

Findings: EP 6 Observed in Tracer Activities at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the Life Safety Code Building Tour the Engineer identified a non-functioning audible alarm that would indicate failure of medical gases in the fourth floor Neonatal Intensive Care Unit. As a result of this finding additional tracer activities were conducted to determine preservation of patient safety in the event of a medical gas failure. From an interview with staff, including physicians, nurses and respiratory therapists, it was observed that none of the clinical staff were aware of the change in the environment produced by the non-functioning audible alarm for a failure of medical gases. The same staff members were unaware of the presence of the alarm lights indicating the non-functioning alarm. From staff interviews, document review and review of past environmental incidents it was observed that the clinical staff effectively responded to a change in the environment to preserve patient safety; however, there was no indication that that changes in the environment, including non-functioning medical gas alarms, are effectively communicated to the clinical staff.

Elements of Performance:

6. When changes in the environment occur, the hospital communicates those changes effectively.

Scoring Category: ACorrective Action Taken:

WHO:

VUH & TVC CEO; VCH CEO; Assistant Vice Chancellor for Facilities and Construction; Executive Director Vanderbilt Environmental Health and Safety

WHAT:

1. Commissioned a third party review of medical gas system operations and maintenance. 2. Developed/implemented Policy SA 10-10.05 Life Safety Systems â€" Area Medical Gas Alarm Panels. 3. Trained NICU Stallman staff 4. Posted signs at Nursing Station and alarm panel locations. 5. Replaced NICU Med Gas Area Alarm Panel.

WHEN:

7/26/2012: signs posted in NICU 7/27/2012: NICU staff trained 7/28/2012: Replaced panel 8/16/2012: third party review commissioned 8/20/2012: policy approved

8/23/2012: All charge nurses and area managers trained

HOW:

1. Commissioned a third party review of medical gas system operations and maintenance. 2. The Medical Gas Alarm Panel Policy was approved by the Medical Center Medical Board. 3. A staff education plan was designed to train the NICU Stallman staff on medical gases and the steps to take in the event of an environment of care incident for patient and staff safety. The plan included the design and deployment of a staff electronic E-Learning Module focused on the medical gases. The medical gas module was distributed electronically to VUMC managers, area supervisors and charge nurses in NICU Stallman. 4. Posted signs at the nursing station and alarm panel locations. 5. Work order was generated in the plant services work management system and assisgned to a qualified staff who performed the work.

HAP Standard LD.04.01.05 The hospital effectively manages its programs, services, sites, or departments.

Findings: EP 4 Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. During the document review and staff discussion it was observed at time of survey that leadership did not ensure that the hospital had a process in place and staff was trained to address alarms and troubles on the fire alarm system. On the 1st day of survey it was observed that the simplex fire alarm system had 26 troubles and the honeywell fire alarm system had 49 troubles. On the 1st day survey the staff monitoring the fire alarm panels and the plant operations staff and the special equipment repair shop staff could not identify the location or the nature of the troubles. Both fire alarm panels indicated the troubles have been active for over 7 days. The hospital conducts all system repairs in house and at time of survey there was no process in place to address these troubles. On day 4 of survey the simplex fire alarm panel had 15 troubles and the honeywell fire alarm system had 46 troubles. Observed in Tracer Activities at NICU at the main hospital. During tracer activities, building tour, and leadership discussion, it was established that there was not an established process to communicate issues in the Life Safety Code functions that could effect safe clinical operations. There was a low oxygen pressure alarm in the Neonatal Intensive Care Unit that the staff had not been notified or educated as to interim measures to protect the patients in that area.

Elements of Performance:

4. Staff are held accountable for their responsibilities.

Scoring Category: ACorrective Action Taken:

WHO:

VUH & TVC CEO; VCH CEO; Assistant Vice Chancellor for Facilities and Construction; Executive Director Vanderbilt Environmental Health and Safety Trained: Delta Staff, NICU Stallman staff

WHAT:

1. Established a Standard Operating Procedure (SOP) [Plant Services Policy 58 "Life Safety System-Trouble/Supervisory Message Response"] to identify response to trouble alarms on the fire alarm system. 2. Commissioned a third party review of fire alarm system. 3. Commission a third party review of medical gas system operations and maintenance. 4. Developed and implemented policy SA 10-10.05 Life Safety Systems - Area Medical Gas Alarm Panel. 5. Delta staff trained on SOP. 6. NICU Stallman staff trained on medical gases.

WHEN:

7/27/2012: SOP established 7/27/2012: Delta staff trained. 7//27/2012: NICU Stallman Staff Trained 8/16/2012: commissioned third party reviews 8/17/2012: completed third party review 8/20/2012: policy approved

HOW:

1. SOP approved by Assist Vice Chancellor for Facilities and Construction. 2. Completed third party review of fire alarm system operations and maintenance. 3. A staff education plan was designed to train staff in NICU Stallman on medical gases and the steps to take in the event of an environment of care incident. The plan included the design and deployment of a staff electronic E-Learning Module focused on the Medical Gases. The Medical Gas module was distributed electronically to VUMC managers, area supervisors and charge nurses of NICU Stallman. 4. The Policy SA 10-10.05 Life Safety Systems â€" Area Medical Gas Alarm Panel was approved by the Medical Center Medical Board. 5. The Delta Staff was provided face to face training by their manager.

HAP Standard LS.02.01.10 Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Findings: EP 4 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Medical Center North building, the fire rating labels on the fire doors were damaged so that the fire rating could not be verified on the following fire

doors; Fire door # 7442, Fire door # 5432, Fire door # 4442. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour it was observed that the fire rating could not be verified on the exit door located on the 4th floor S 2 center exit stair. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour it was observed that the fire rating could not be verified on the fire door located on the 2nd floor N mechanical room of the VUH building. EP 9 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VPH building it was observed that the fire wall at exit stair # 2086, had a penetration that was not properly sealed. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Medical Center North building it was observed that the fire wall at exit stair # 02100, had a penetration that was not properly sealed. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Children Hospital building it was observed that the fire wall at door # 8404, had a penetration that was not properly sealed. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH building it was observed on the 4th floor at the double fire doors near TVC north elevator lobby, above the ceiling the fire wall had a penetration that was not properly sealed. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH it was observed in the 2nd floor north mechanical room, the fire wall had a penetration that was not properly sealed.

Elements of Performance:

4. Openings in 2-hour fire-rated walls are fire rated for 1 1/2 hours. (See also LS.02.01.20, EP 3; LS.02.01.30, EP 1) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1)

Scoring Category: ACorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction; Director of Operations & Compliance for Medical Center Plant Services

WHAT:

1. Removed paint from rating labels for all Medical Center North fire door locations referenced. 2. Ordered and installed replacement fire doors for the VUH locations referenced. 3. EOC survey process revised.

WHEN:

7/24/2012: removed paint 8/9/2012: revised EOC indicator 8/24/2012: installed doors

HOW:

1.A work order was generated in the Plant Services work management system and assigned to Paint Shop staff who removed paint from door rating labels for the Medical Center North fire doors referenced and to Carpentry Shop staff who installed new fire rated doors for the VUH doors referenced. 2. Revised EOC survey process to include indicator for inspection of labels on rated doors.

9. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are protected with an approved fire-rated material. Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2)

Scoring Category: CCorrective Action Taken:

WHO:

Assistant Vice Chancellor for Facilities and Construction; Director of Utilities & Construction for Medical Center Plant Services

WHAT:

Sealed penetrations referenced.

WHEN:

8/3/12

HOW:

1. A Work order was generated in the Plant Services work management system and assigned to qualified Carpentry Shop staff who physically sealed the penetrations referenced. 2.Implemented the above ceiling permit program for standardization of sealing penetrations. Work was completed by certified staff.

HAP Standard LS.02.01.20 The hospital maintains the integrity of the means of egress.

Findings: EP 13 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT

MET as evidenced by: Observed in Tracer Activities at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During tracer activity three C-arms were stored in the bridge joining the perioperative services with the Vanderbilt Clinic. These C-arms were obstructing the clear exit for discharge. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Medical Center North building, it was observed that the means of exit egress on the 5th floor, exits through a business occupancy building and the means of exit egress was not clear of obstructions or impediments to the public way. Trash and recycle containers greater than 32 gals were stored in the egress corridor as well as carts and furniture. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH it was observed in the emergency department pod A, the means of exit egress was not clear of obstructions or impediments to the public way. It was observed that equipment, carts and stretchers were stored in the egress corridors. The emergency department pod A was not identified as a suite. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Medical Center North building, it was observed that the means of exit egress on the 6th floor, exits through a business occupancy building and the means of exit egress was not clear of obstructions or impediments to the public way. Trash and recycle containers greater than 32 gals were stored in the egress corridor as well as carts and furniture. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Medical Center North building, it was observed that the means of exit egress on the 7th floor, exits through a business occupancy building and the means of exit egress was not clear of obstructions or impediments to the public way. Trash and recycle containers greater than 32 gals were stored in the egress corridor as well as carts and furniture. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH it was observed in the emergency department pod B, the means of exit egress was not clear of obstructions or impediments to the public way. It was observed that equipment, carts and stretchers were stored in the egress corridors. The emergency department pod B was not identified as a suite. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH it was observed in the emergency department fast track, the means of exit egress was not clear of obstructions or impediments to the public way. It was observed that equipment, carts and stretchers were stored in the egress corridors. The emergency department fast track was not identified as a suite. EP 31 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VPH it was observed that 2 exit sign were missing on the adult wing. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH it was observed in the mechanical room B406, exit signs were

missing. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH it was observed in the mechanical room B405, exit signs were missing.

Elements of Performance:

13. Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text and any exceptions, refer to NFPA 101-2000: 7.1.10.1)

Scoring Category: CCorrective Action Taken:

WHO:

VUH & TVC CEO; Assist Vice-Chancellor for Facility Services and Construction. Assistant Director Vanderbilt Environmental Health & Safety

WHAT:

1. Removed obstructions from path of egress for all locations referenced to maintain clear corridor and clear exit. 2.Identified alternate (permanent) location for C-Arm, trash and recycle container storage and moved these items to new locations. 3.Communicated trash and recycle container storage plan with Medical School Environmental Services. 4.Established a reporting process for EOC Survey results to Hospital Leadership. 5.Communicated egress standard requirement to hospital unit managers by senior leadership.

WHEN:

8/3/12: Met with involved departments to resolve egress issues and removed obstructions 8/10/12: Established communication process to executive leadership 8/27/12: communicated egress standard requirements to managers

HOW:

1. Plant Services met with Radiology Services regarding C-arm obstructions, Environmental Services with respect to trash and recycle container obstructions, and with Directors and Managers of the VUH ED regarding egress impediments within the ED to create an action plan to resolve these issues. Alternate and permanent storage locations for C-arms and trash and recycle containers were identified that did not obstruct the clear exit for discharge or means of egress and these items were moved accordingly. ED staff removed obstructions from egress corridors within their area. 2. Established a communication process to report results of the EOC Surveys to Executive leadership quarterly. 3. Senior leadership communicated egress standard requirements via email to hospital unit managers.

31. Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are 4 or more inches high (or 6 inches high if externally lit). (For full text and any exceptions, refer to NFPA 101-2000: 7.10.1.2, 7.10.5, 7.10.6.1, and 7.10.7.1)

Scoring Category: CCorrective Action Taken: 143

WHO:

Assist Vice-Chancellor for Facility Services and Construction; Director of Operations & Compliance for Medical Center Plant Services

WHAT:

Installed missing exit signs.

WHEN:

8/8/12

HOW:

1.The Plant Services Team met with VUMC senior leadership to design and implement the action plan below to ensure compliance with LS.02.01.20 2. A Work order was generated in the Plant Services work management system and assigned to qualified Electric Shop staff who installed the exit signs at the locations referenced. 3. The established EOC survey process monitors exit signs. The EOC survey results are shared with Executive leadership quarterly.

HAP Standard LS.02.01.30 The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Findings: EP 11 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH building it was observed that the corridor door near elevator 11 did not have positive latching hardware installed. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH building it was observed that the corridor door 1465 located in the emergency department did not have positive latching hardware installed. The emergency department was not identified as a suite. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH building it was observed that the corridor door 1466 located in the emergency department did not have positive latching hardware installed. The emergency department was not identified as a suite. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH building it was observed that the

corridor door 1462 located in the emergency department did not have positive latching hardware installed. The emergency department was not identified as a suite. EP 18 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VPH, it was observed that the smoke wall at door 1101 had a penetration that was not properly sealed. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH, it was observed that the smoke wall near the CCT elevator lobby on the 1st floor, had a penetration that was not properly sealed. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH, it was observed in electrical closet 1364, the smoke wall had a penetration that was not properly sealed. The electrical closet did not have a ceiling and was not properly sealed to deck above.

Elements of Performance:

11. Corridor doors are fitted with positive latching hardware, are arranged to restrict the movement of smoke, and are hinged so that they swing. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 1 inch. Roller latches are not acceptable. Note: For existing doors, it is acceptable to use a device that keeps the door closed when a force of 5 foot-pounds are applied to the edge of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.6.3.2, 18/19.3.6.3.1, and 7.2.1.4.1)

Scoring Category: CCorrective Action Taken:

WHO:

Assist Vice-Chancellor for Facility Services and Construction; Director of Utilities & Construction for Medical Center Plant Services. Trained: Plant Services staff

WHAT:

1. Installed positive latching for the door near elevator 11. 2. Obtained Proposal from the door manufacturer's local representative/installer for doors that include positive latching. Issued a Purchase Order accordingly and scheduled installation for completion based on anticipated receipt of materials by installer. 3.Interim Life Safety assessment performed and plan implemented. 4.Retrained plant services staff on SA 40-10.05 Interim Life Safety Implementation.

WHEN:

8/3/12: installed door near elevator 11 8/8/12: obtained

Proposal 9/21/12: new ED doors received 9/7/2012: Interim Life Safety Measure performed and plan implemented

HOW:

1. A Work Order was generated in the Plant Services work management system and assigned to qualified Carpentry Shop staff who physically installed positive latching hardware for the door near elevator 11. 2. A work Order was generated in the Plant Services work management system associated with the Proposal and issuing of a Purchase Order for the Emergency Department doors requiring positive latching. 3. Notified Emergency Room Management of the door positive latching Interim Life Safety Measure. 4.Posted interim Life Safety Measure in Emergency Room Department 5.Retrained Plant Services Staff regarding Interim Life Safety implementation Policy.

18. Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.3)

Scoring Category:

CCorrective Action Taken:

WHO:

Assist Vice-Chancellor for Facility Services and Construction; Director of Utilities & Construction for Medical Center Plant Services

WHAT:

Sealed penetrations referenced and sealed to deck in electrical closet 1364.

WHEN:

7/27/12

HOW:

1. The Plant Services Team met with VUMC senior leadership to design and implement the action plan below to ensure compliance with LS.02.01.30 EP 18 (C) evidenced by resolution of findings and maintaining and or implementing standardized, systematic processes to sustain a safe patient and staff environment evidenced by the following: 2. A Work order was generated in the Plant Services work management system and assigned to qualified Carpentry Shop staff who physically sealed the penetrations referenced. 3.Implemented the above ceiling permit program for standardization of sealing penetrations. Work was completed by certified staff.

HAP Standard LS.02.01.35 The hospital provides and maintains systems for extinguishing fires.

Findings: EP 4 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of Medical Center North building it was observed near room S 5 405 cables were tied to the sprinkler piping. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of Medical Center North building it was observed near room S 5 429 cables were tied to the sprinkler piping. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of VUH building it was observed on the 2nd floor near mechanical room south, cables were tied to the sprinkler piping. EP 5 Â§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101Â®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Tracer Activities at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During tracer activity in the Oral Surgery Clinic, it was observed that there was an accumulation of dust on a sprinkler head located in the dirty utility room. Observed in Tracer Activities at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During tracer activity in the Hematology clinic, it was observed that there was an accumulation of dust on the sprinkler head. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the VUH it was observed in the soiled utility room 4206, plastic was wrapped around the sprinkler head. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Children hospital it was observed it the kitchen, sprinkler head # 1 and # 2 was not free from foreign materials. Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. During the building tour of the Children hospital it was observed it Subway's kitchen, sprinkler head # 3 and # 4 was not free from foreign materials.

Elements of Performance:

4. Piping for approved automatic sprinkler systems is not used to support any other item. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.2)

Scoring Category: CCorrective Action Taken:

WHO:

Assist Vice-Chancellor for Facility Services and Construction; Director of Utilities & Construction for Medical Center Plant Services

WHAT:

Relocated cables.

WHEN:

7/27/2012

HOW:

1. A Work order was generated in the Plant Services work management system and assigned to qualified Electric Shop staff who physically relocated the cables. 2.Implemented the above ceiling permit program for requirements related to sprinkler heads piping. Work was completed by staff with current certification.

5. Sprinkler heads are not damaged and are free from corrosion, foreign materials, and paint. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.1.1)

Scoring Category: CCorrective Action Taken:

WHO:

Assist Vice-Chancellor for Facility Services and Construction; Director of Utilities & Construction for Medical Center Plant Services; Manager of VUMC Plumbing Shop Trained: EVS staff

WHAT:

1. Cleaned sprinkler heads. 2. Trained Environmental. Services(EVS) to clean sprinkler heads.

WHEN:

8/3/12: cleaned sprinkler heads 8/8/12: trained EVS 8/9/2012: indicator added to EOC survey process

HOW:

1.A Work Order was generated in the Plant Services work management system and assigned to qualified Plumbing Shop staff who physically cleaned the sprinkler heads. 2.Trained environmental services staff for ongoing cleaning through face to face demonstration. 3.The established EOC survey process has been revised to include observation of sprinkler heads. Established communication to Executive leadership of EOC Survey Results quarterly.

Vanderbilt University Hospital and The Vanderbilt Clinic

Organization ID: 7892

1211 22nd Avenue SouthNashville, TN 37232-2101

Accreditation Activity - 45-day Evidence of Standards Compliance Form

Due Date: 10/28/2012

HAP Standard LS.01.02.01 **The hospital protects occupants during periods when the Life Safety Code is not met or during periods of construction.**

Findings: EP 3 Observed in Document Review at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site. In review of deficiencies noted from the 7/12 survey, the organization failed to assess and implement ILSM's according to the policy in place (ex. Doors found noncompliant at LS.02.01.30 EP11). This issue was immediately corrected by leadership and AFS10 is not warranted.

Elements of Performance:

3. The hospital has a written interim life safety measure (ILSM) policy that covers situations when Life Safety Code deficiencies cannot be immediately corrected or during periods of construction. The policy includes criteria for evaluating when and to what extent the hospital follows special measures to compensate for increased life safety risk. (See also LS.01.01.01, EP 3)

Scoring Category: A

Corrective Action Taken:

WHO:

Assist Vice-Chancellor for Facility Services and Construction; Director Operations & Compliance for Medical Center Plant Services; Trained: Plant Services and Space and Facilities Staff

WHAT:

1. The Identified Interim Life Safety Measures(ILSM) were created and implemented according to hospital policy SA 40-10.05, Interim Life Safety Implementation. 2. Notified the Emergency Department Clinical Management of the Interim Life Safety Measure status. 3. Posted Interim Life Safety Measure notification in Emergency Department. 4. Created and implemented a PFI due to extension of work process for installation of doors. 5. Revised the standardized process that ILSMs are implemented when a life safety issue is identified. 6. Trained Plant Services and Space and Facilities Staff on revised ILSM process.

WHEN:

9/6/12 created ILSM 9/6/12 notified ED 9/6/12 posted ILSM 9/7/12 created PFI 9/20/12 Revised ILSM process 9/20/12 trained Plant Services and Space and Facilities Staff

HOW:

1. The Plant Services leadership identified and created an ILSM to address the door safety issue. The Plant Services leadership then deployed qualified staff and implemented the ILSM process. 2. Notified the ED Clinical Management of the Interim Life Safety Measure,face to face. 3. Posted an Interim Life Safety Measure in the Emergency Department (ED). 4. Created and implemented a PFI while awaiting door installation. 5. Plant Services leadership created a reliable, standardized ILSM process which requires staff to sign off on each ILSM assessment. ILSMs are regularly reviewed by Plant Services Management to verify ILSM assessment and implementation occurs. 6. Trained Plant Services and Space and Facilities Staff regarding revised ILSM process , face to face.

Vanderbilt University Hospital and The Vanderbilt Clinic

Organization ID: 7892

1211 22nd Avenue SouthNashville, TN 37232-2101

Accreditation Activity - 60-day Evidence of Standards Compliance Form

Due Date: 11/12/2012

HAP Standard LS.02.01.20 The hospital maintains the integrity of the means of egress.

Findings: §482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. EP 13 not cleared, during building tour of 7th floor noted many carts and other equipment stored in corridors. §482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. EP 13 not cleared, during building tour of 7th floor noted many carts and other equipment stored in corridors.

Elements of Performance:

13. Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text and any exceptions, refer to NFPA 101-2000: 7.1.10.1)

Scoring Category: C

Corrective Action Taken:

WHO:

Assist Vice-Chancellor for Facility Services and Construction; Director of Operations & Compliance for Medical Center Plant Services; Assistant Director Vanderbilt Environmental Health & Safety; VUH & TVC COO

WHAT:

1. Removed obstructions from path of egress for all locations referenced to maintain clear corridor and clear exit. 2. Re-communicated egress standard requirement to hospital unit managers by senior leadership. 3. Communicated Environment of Care (EOC) survey results to Hospital Leadership.

WHEN:

8/10/2012: EOC process changed 9/6/12: Date obstructions cleared 10/26/12: Re-communication to managers

HOW:

1. Cleared carts and equipment from 7th Floor Roundwing corridors. 2. Senior leadership re-communicated egress standard requirements via email to hospital unit managers. 3. The EOC survey process includes monitoring of compliance with the required standard. EOC survey process changed to include reporting of survey results to Executive leadership quarterly.

HAP Standard LS.02.01.30 The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Findings: §482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. EP11 not cleared. §482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. This Standard is NOT MET as evidenced by: Observed in Building Tour at Vanderbilt University Hospital and The Vanderbilt Clinic (1211 21st Avenue South, Nashville, TN) site for the Hospital deemed service. EP11 not cleared.

Elements of Performance:

11. Corridor doors are fitted with positive latching hardware, are arranged to restrict the movement of smoke, and are hinged so that they swing. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 1 inch. Roller latches are not acceptable. Note: For existing doors, it is acceptable to use a device that keeps the door closed when a force of 5 foot-pounds are applied to the edge of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.6.3.2, 18/19.3.6.3.1, and 7.2.1.4.1)

Scoring Category: C

Corrective Action Taken:

WHO:

Assist Vice-Chancellor for Facility Services and Construction; Director of Utilities & Construction for Medical Center Plant Services

WHAT:

1. Obtained proposal from the door manufacturer's local representative / installer for replacement doors that include positive latching. 2. Issued a Purchase Order and scheduled installation for completion based on anticipated receipt of materials by installer. 3. Notified Emergency Department management of the door positive latching Interim Life Safety Measure. 4. Posted interim Life Safety Measure in Emergency Department(ED). 5. Created and implemented a PFI while awaiting door installation. 6. Completed installation of ED doors.

WHEN:

8/7/12: Proposal received from door supplier 8/16/12: Purchase Order completed; 9/6/12: Notified Emergency Department management and posted ILSM information 9/7/12: Created PFI 10/15/12: ED doors installation completed

HOW:

1. A Work Order was generated in the Plant Services work management system associated with the proposal and issuing of a Purchase Order for the Emergency Department doors requiring positive latching. 2. Notified Emergency Department management of the door positive latching Interim Life Safety Measure, face to face. 3. Posted Interim Life Safety Measure in Emergency Department. 4. The ED doors were installed by qualified staff.

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Vanderbilt University Hospital and The Vanderbilt Clinic

Organization ID: 7892

1211 22nd Avenue SouthNashville, TN 37232-2101

Accreditation Activity - Measure of Success Form

Due Date: 2/14/2013

BHC Standard CTS.03.01.03 The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

Elements of Performance:

3. The objectives of the plan for care, treatment, or services meet the following criteria: - They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3) - They are sufficiently specific to assess the progress of the individual served - They are expressed in terms that provide indices of progress

Scoring Category: C
Stated Goal (%): 90
Month 1 Date: 10/2012
Month 1 Actual Goal (%): 100
Month 2 Date: 11/2012
Month 2 Actual Goal (%): 100
Month 3 Date: 12/2012
Month 3 Actual Goal (%): 97
Month 4 Date: 01/2013
Month 4 Actual Goal (%): 95
Actual Average Goal (%): 98
Optional Comments: Month 1: 36/36 = 100% Month 2: 42/42 = 100% Month 3: 33/34 = 97% Month 4: 39/41 = 95% Actual Average Goal: 150/153 = 98%

HAP Standard EC.03.01.01 Staff and licensed independent practitioners are familiar with their roles and responsibilities relative to the environment of care.

Elements of Performance:

2. Staff and licensed independent practitioners can describe or demonstrate actions to take in the event of an environment of care incident. (See also EC.02.03.01, EP 10 and HR.01.04.01, EP 1)

Scoring Category: C
Stated Goal (%): 90
Month 1 Date: 10/2012
Month 1 Actual Goal (%): 90
Month 2 Date: 11/2012
Month 2 Actual Goal (%): 100
Month 3 Date: 12/2012
Month 3 Actual Goal (%): 100
Month 4 Date: 01/2013
Month 4 Actual Goal (%): 100
Actual Average Goal (%): 97
Optional Comments: Month 1: 36/40 = 90% Month 2: 42/42 = 100% Month 3: 38/38 = 100% Month 4: 39/39 = 100% Actual Average Goal: 155/159 = 97%

HAP Standard PC.01.02.07 The hospital assesses and manages the patient's pain.

Elements of Performance:

3. The hospital reassesses and responds to the patient's pain, based on its reassessment criteria.

Scoring Category: C
Stated Goal (%): 90
Month 1 Date: 10/2012
Month 1 Actual Goal (%): 92
Month 2 Date: 11/2012
Month 2 Actual Goal (%): 96
Month 3 Date: 12/2012
Month 3 Actual Goal (%): 97
Month 4 Date: 01/2013
Month 4 Actual Goal (%): 97
Actual Average Goal (%): 95
Optional Comments: Month 1: 315/344 Month 2: 302/316 Month 3: 315/326 Month 4: 308/319 1240/1305 = 95%

Proof of Publication

Public Notices

0101680794

SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on **November 5, 2013 at 10:00 AM local time**, at the Davidson County Courthouse, South Main door, One Public Square, Nashville, Tennessee pursuant to Deed of Trust executed by Kevin A. Vaughn and Beverly G. Vaughn, Husband and Wife, to First Title Corp., Trustee, as trustee for Mortgage Electronic Registration Systems, Inc. ("MERS"), solely as nominee for New Freedom Mortgage Corporation on March 21, 2006 at Instrument No. 20060515-0056733; conducted by Shapiro & Kirsch, LLP having been appointed Substitute or Successor Trustee, all of record in the Davidson County Register's Office.
Default has occurred in the performance of the covenants, terms, and conditions of said Deed of Trust and the entire indebtedness has been declared due and payable.
Party Entitled to Enforce the Debt: Wells Fargo Bank, NA, its successors and assigns
The following real estate located in Davidson County, Tennessee, will be sold to the highest call bidder:
All that certain property

Continued from last column

Street Address: 620 Marswen Drive, Nashville, Tennessee 37216
Parcel Number: 061 02 0 033.00
Current Owner(s) of Property: Kevin A. Vaughn and wife, Beverly G. Vaughn
Other interested parties: American General Financial Services, Inc., Hudson & Keyse, L.L.C. c/o Christopher W. Conner, Attorney and Arrow Financial Services LLC as Assignee of GE Money BK/HH Gregg c/o Grisham, Knight & Hooper
The street address of the above described property is believed to be 620 Marswen Drive, Nashville, Tennessee 37216, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description herein shall control.
SALE IS SUBJECT TO TENANT(S) RIGHTS IN POSSESSION.
This sale is subject to all matters shown on any applicable recorded plat any unpaid taxes; and any restrictive covenants, easements, or setback lines that may be applicable; any statutory right of redemption of any governmental agency, state or federal; any prior liens or encumbrances as well as any priority created by a fixture filing; and to any matter that an accurate survey of the premises might disclose.
In addition, the following parties may claim an interest in the above-referenced property: American General Financial Services, Inc., Hudson & Keyse, L.L.C. c/o Christopher W. Conner, Attorney and Arrow Financial Services LLC as Assignee of GE Money BK/HH Gregg c/o

Continued from last column

in twenty-four (24) hours of the sale, the next highest bidder, at their highest bid, will be deemed the successful bidder.
This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded by the Substitute Trustee at any time.
This office may be a debt collector. This may be an attempt to collect a debt and any information obtained may be used for that purpose.
Shapiro & Kirsch, LLP Substitute Trustee
www.kirschattorneys.com
Law Office of Shapiro & Kirsch, LLP
555 Perkins Road Extended, Second Floor
Memphis, TN 38117
Phone (901)767-5566
Fax (901)761-5690
File No. 13-051914

0101680925

SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on **November 7, 2013 at 10:00 AM local time**, at the Auction.com Room of the Schermerhorn Symphony Center, One Symphony Place, Nashville, TN 37201, conducted by Shapiro & Kirsch, LLP Substitute Trustee, pursuant to Deed of Trust executed by Kenneth L. Givens Rebecca Givens Husband and wife, to Jeanne White, Trustee, on February 29, 2008 at Instrument No. 20080310-0024150; all of record in the Davidson County Register's Office.
Party entitled to enforce security interest: JPMorgan Chase Bank, National Association, its successors and assigns
The following real estate located in Davidson County, Tennessee, will be sold to the highest call bidder:

Continued from last column

Current Owner(s) of Property: Kenneth L. Givens and wife, Rebecca Givens
The street address of the above described property is believed to be 1422 Electric Avenue, Nashville, Tennessee 37206, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description referenced herein shall control.
SALE IS SUBJECT TO TENANT(S) RIGHTS IN POSSESSION.
All right of equity of redemption, statutory and otherwise, and homestead are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.
If the highest bidder cannot pay the bid within twenty-four (24) hours of the sale, the next highest bidder, at their highest bid, will be deemed the successful bidder.
This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded at any time.
Shapiro & Kirsch, LLP Substitute Trustee
www.auction.com
Law Office of Shapiro & Kirsch, LLP
555 Perkins Road Extended, Second Floor
Memphis, TN 38117
Phone (901)767-5566
Fax (901)761-5690
File No. 13-051986

0101680950

SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on **October 1, 2013 at 10:00 AM local time**, at the Davidson County Courthouse, South Main door, One Public

Continued from last column

tions of said Deed of Trust and the entire indebtedness has been declared due and payable.
Party Entitled to Enforce the Debt: Wells Fargo Bank, NA, its successors and assigns
The following real estate located in Davidson County, Tennessee, will be sold to the highest call bidder:
A Certain tract or parcel of land in Davidson County, State of Tennessee, described as follows, to-wit:
Land in Davidson County, Tennessee, being Lot No. 21, on the Plan of Piccadilly Subdivision, Section 4, a plat of which is of record in Book 6900, page 481, Register's Office for Davidson County, Tennessee, to which plat reference is hereby made for a more complete description of said lot.
BEING the same property conveyed to Bruce Cheatom, Jr. and Theresa Cheatom by deed recorded 03/13/95 in Book 9616, Page 919.
Street Address: 433 London Court, Antioch, Tennessee 37013
Parcel Number: 149 02 0D 021.00
Current Owner(s) of Property: Bruce Cheatom, Jr. and wife, Theresa Cheatom, married
The street address of the above described property is believed to be 433 London Court, Antioch, Tennessee 37013, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description herein shall control.
SALE IS SUBJECT TO TENANT(S) RIGHTS IN POSSESSION.
This sale is subject to all matters shown on any applicable recorded plat any unpaid taxes; and any restrictive cove-

Continued from last column

only as Substitute Trustee.
The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above. If the highest bidder cannot pay the bid within twenty-four (24) hours of the sale, the next highest bidder, at their highest bid, will be deemed the successful bidder.
This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded by the Substitute Trustee at any time.
This office may be a debt collector. This may be an attempt to collect a debt and any information obtained may be used for that purpose.
Shapiro & Kirsch, LLP Substitute Trustee
www.kirschattorneys.com
Law Office of Shapiro & Kirsch, LLP
555 Perkins Road Extended, Second Floor
Memphis, TN 38117
Phone (901)767-5566
Fax (901)761-5690
File No. 13-051124

0101682636

SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on **November 12, 2013 at 10:00 AM local time**, at the east door, Sumner County Courthouse, Gallatin, Tennessee pursuant to Deed of Trust executed by Nicholas A. Deford and Amie E. Deford, husband and wife, as joint tenants with right of survivorship, to Hugh M. Queener, Trustee, as trustee for Mortgage Electronic Registration Systems, Inc. ("MERS"), solely as

Continued from last column

Party Entitled to Enforce the Debt: Wells Fargo Bank, NA, its successors and assigns
The following real estate located in Sumner County, Tennessee, will be sold to the highest call bidder:
Land in Sumner County, Tennessee, being Lot No. 42, Brooklawn Terrace Subdivision, Section II, as shown on plat of record in Plat Book 6, Pages 21, 22, 23 and 24, in the Register's Office for Sumner County, Tennessee, to which plat reference is here made for a more detailed description. Description taken from prior deed of record.
Street Address: 118 Sunset Place, Hendersonville, Tennessee 37075
Parcel Number: 160E-E-004.00
Current Owner(s) of Property: Nicholas A. Deford and Amie E. Deford, husband and wife
The street address of the above described property is believed to be 118 Sunset Place, Hendersonville, Tennessee 37075, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description herein shall control.
SALE IS SUBJECT TO TENANT(S) RIGHTS IN POSSESSION.
This sale is subject to all matters shown on any applicable recorded plat any unpaid taxes; and any restrictive covenants, easements, or setback lines that may be applicable; any statutory right of redemption of any governmental agency, state or federal; any prior liens or encumbrances as well as any priority created by a fixture filing; and to any matter that an accurate survey of the prem-

Continued from last column

in twenty-four (24) hours of the sale, the next highest bidder, at their highest bid, will be deemed the successful bidder.
This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded by the Substitute Trustee at any time.
This office may be a debt collector. This may be an attempt to collect a debt and any information obtained may be used for that purpose.
Shapiro & Kirsch, LLP Substitute Trustee
www.kirschattorneys.com
Law Office of Shapiro & Kirsch, LLP
555 Perkins Road Extended, Second Floor
Memphis, TN 38117
Phone (901)767-5566
Fax (901)761-5690
File No. 12-044383

Public Notices

0101682600

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency,
that: Vanderbilt University Hospitals, an existing acute care hospital owned by Vanderbilt University, with an ownership type of not-for-profit, and to be managed by: Vanderbilt University Hospitals, intends to file an application for a Certificate of Need
for the expansion and renovation to the existing third floor operating suite by four operating rooms and by providing shell space for future expansion of two additional operating rooms at 1211 Medical Center Drive, Nashville, TN. Project costs include the four new operating rooms and associated equipment costs. The estimated project cost is $7,535,708.64. No major medical equipment will be involved. The total number of licensed beds will not change as a result of this project.
The anticipated date of filing the application is: September 13, 2013.
The contact person for this project is Ronald W. Hill, Vice President, Business Development who may be reached at: Vanderbilt University Medical Center, 3319 West End Avenue, Suite 920, Nashville, TN 37203. 615-936-6012
Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted.
Written requests for hearing should be sent to:
Health Services and Development Agency
The Frost Building, Third Floor
161 Rosa L. Parks Boulevard
Nashville, Tennessee 37243
The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

COPY-

SUPPLEMENTAL-1

Vanderbilt University Hospitals

CN1309-034

SUPPLEMENTAL- # 1
September 27, 2013
10:58 am

State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

Ronald W. Hill
Vice President, Business Development
Vanderbilt University Medical Center
3319 West End Avenue, Suite 920
Nashville, TN 37203

RE: Certificate of Need Application CN1309-034
Vanderbilt University Hospitals

Dear Mr. Hill:

This will acknowledge our September 13, 2013 receipt of your application for a Certificate of Need for the expansion and renovation to the existing third floor operating suite by four operating rooms and by providing shell space for future expansion of two additional operating rooms at 1211 Medical Center Drive, Nashville (Davidson County), TN.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 p.m., Friday, September 27, 2013. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

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1. **Section A, Applicant Profile, Item 13**

   Please clarify if Vanderbilt University Hospital is contracted with TennCare Select.

   Response: Yes, Vanderbilt University Hospital is contracted with TennCare Select.

2. **Section B, Project Description, Item 1**

   Please provide a brief description of staffing.

   Response: VUH ORs are staffed with surgical nurses, surgical techs and other ancillary support appropriate to the acuity of the case. In total VUH employs approximately 354 surgical nurses, 124 surgical techs, 39 nurse managers and 405 other ancillary support positions that assist in ORs cases. In general, the staffing for a surgery suite consists of those positions provided in the application, which include nurses, surgical techs and nurse manager/ facility administrator.

   What is the current number of operating rooms located on the third floor of Vanderbilt University Hospital?

   Response: The current number of operating rooms on the third floor of VUH is 46.

When does the applicant project that shell space will need to be finished and available as OR's?

Response: Currently, these two shelled ORs are anticipated to be built out only when volume justifies their opening. Given that construction to the area will involve extensive mechanical and electrical work, it makes sense to shell the additional two rooms so they are available for later use with minimal disruption.

3. **Section B, Project Description, Item III (Plot Plan)**

Please provide a Plot Plan with the size of the site (in acres).

Response: Please see attached plot plan that shows the medical center is approximately 16.5 acres and VUH is approximately 2.3 acres. (Attachment 1)

4. **Section C, Need, Item 1.**

STATE HEALTH PLAN

Tennessee Code Annotated Section 68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at http://www.tn.gov/finance/healthplanning/). The State Health Plan guides the state in the development of health care programs and policies and in the allocation of health care resources in the state, including the Certificate of Need program. The 5 Principles for Achieving Better Health form the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Please discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan. Each Principle is listed below with example questions to help the applicant in its thinking.

1. The purpose of the State Health Plan is to improve the health of Tennesseans.

    a. How will this proposal protect, promote, and improve the health of Tennesseans over time?

    Response: The addition of four ORs at VUH will provide additional capacity for the many state residents who choose to access VUH. Surgical intervention promotes health in that it can relieve otherwise debilitating conditions. Examples include surgical weight loss interventions, which reduce possible comorbidities associated with obesity, and joint replacement surgery, which allows for continued active lifestyles.

    b. What health outcomes will be impacted and how will the applicant measure improvement in health outcomes?

    Response: All surgical outcomes are reviewed on a regular basis by numerous teams including the Perioperative Executive Committee (meets weekly) and the Perioperative Enterprise Committee (meets monthly). The Perioperative Enterprise Committee reports directly to the Medical Center Medical Board.

Outcomes include metrics associated with any adverse event, wound infection rates, mortality and other indicators. Specific quality improvement and patient safety interventions are implemented in response to these data.

How does the applicant intend to act upon available data to measure its contribution to improving health outcomes?

Response: Feedback to surgeons and surgical teams provides comparative information benchmarked internally and externally by using standards such as those in use by the Joint Commission (National Patient Safety Goals), University Healthsystem Consortium, Tennessee Center for Performance Excellence, The Leapfrog Group, and Magnet.

2. Every citizen should have reasonable access to health care.

   a. How will this proposal improve access to health care? You may want to consider geographic, insurance, use of technology, and disparity issues (including income disparity), among others.

   Response: Additional surgical capacity at VUH will provide increased access for all patients regardless of geographic origin, race, gender or financial considerations. VUH is both a Level I trauma center as well as a major safety net hospital providing over $370 million per year to indigent and uninsured populations. VUH houses many unique innovative technologies.

   b. How will this proposal improve information provided to patients and referring physicians?

   Response: An electronic health record is in place at VUH that can be accessed by physicians and the MyHealthatVandy patient portal is in place for communications between patients and their physician providers. Surgical case information and discharge summaries are available to referring physicians through the Provider Communication Wizard.

   c. How does the applicant work to improve health literacy among its patient population, including communications between patients and providers?

   Response: VUH has an entire array of resources devoted to patient satisfaction, and these resources include information about disease conditions and appropriate treatment modalities for patient use. Providers are coached regarding important attributes of effective interaction with patients. In addition, an active translation service is available for those patients with difficulty with the English language.

3. The State's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the State's health care system.

a. How will this proposal lower the cost of health care?

Response: VUH has mechanisms in place to assure the right kind of care is delivered at the right time and place. As such, system costs will be reduced if only the right intervention is implemented and inappropriate interventions are avoided.

b. How will this proposal encourage economic efficiencies?

Response: Economic efficiencies are achieved by mechanisms in place through the Perioperative Executive Committee (meets weekly) and the Perioperative Enterprise Committee (meets monthly) programs that review outcomes and appropriateness of interventions.

c. What information will be made available to the community that will encourage a competitive market for health care services?

Response: As the health care industry transforms, additional health care systems and associated insurance exchanges will become available to the community. These exchanges will provide transparent market data allowing for better choices by consumers.

4. Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.

a. How will this proposal help health care providers adhere to professional standards?

Response: All surgical outcomes are reviewed on a regular basis by the Perioperative Executive Committee (meets weekly) and the Perioperative Enterprise Committee (meets monthly). Feedback to surgeons and surgical teams provides comparative information so that improvement is benchmarked both internally and externally.

b. How will this proposal encourage continued improvement in the quality of care provided by the health care workforce?

Response: Those trained to participate in the extensive quality control mechanisms in place at VUH will be able to help implement similar quality improvement programs in other venues.

5. The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.*

a. How will this proposal provide employment opportunities for the health care workforce?

Response: Additional staffing will be needed for the proposal. Even in a time of employee reductions at most hospitals, patient care related positions remain a priority at VUH.

b. How will this proposal complement the existing Service Area workforce?

Response: VUH participates in training programs for physicians, nurses, and allied healthcare workers.

5. Section C, Need, Item 1.a. (Project Specific Criteria-Construction, Renovation, Expansion)

Please complete the Project Specific Criteria Construction Renovation, Expansion and Replacement of Health Care Institutions.

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

Response: Not applicable because the project does not include beds, services, or medical equipment to be reviewed under the standards.

2. For relocation or replacement of an existing licensed health care institution:

Response: Not applicable because it is not a relocation or replacement of an existing licensed health care institution.

a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

3. For renovation or expansions of an existing licensed health care institution:

a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

Response: The proposed project is a consequence of high current surgical volume and projections for future growth as patients continue to access the subspecialty surgical care available at Vanderbilt. Patients from an extended service area, including patients from out of state, utilize the facility. There were roughly 30,645 adult surgical cases at VUH in FY13. In addition, the Vanderbilt surgical case volume currently at the Nashville Surgery

Center will be relocated to VUH in October 2014, resulting in approximately 3,000 additional cases. As a result of this relocation and the demand for surgical services, it is projected that there will be approximately 38,600 surgical cases by FY17 at VUH.

In order to meet these volume projections, the additional operating rooms are necessary.

b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

Response: The area proposed in this project is immediately adjacent to existing surgical capacity within VUH. The proposed project will achieve operational efficiencies by expanding the operating room capacity adjacent to the existing operating rooms at VUH. This expansion will also improve patient flow and care coordination by utilizing existing resources. Vanderbilt is committed to an evidenced-based approach to the delivery of care, which will also assure cost-effective approaches to patient care.

6. Section C, Need, Item 2

The applicant states the Vanderbilt Surgical volume currently at the Nashville Surgery Center will be relocated to VUH in October 2012, resulting in approximately 3,000 additional cases. Please address the following questions in relation to the previous statement:

- What is the applicant's relationship to Nashville Surgery Center?

  Response: Vanderbilt, through its Vanderbilt Health Services, has a 40% ownership position in the Nashville Surgery Center. Surgical Care Affiliates owns the other 60% of the facility and manages the facility.

- Why are the 3,000 cases being transferred from Nashville Surgery Center to VUH?

  Response: Vanderbilt intends to consolidate the surgical cases currently at Nashville Surgery Center as a strategic and operational priority once additional capacity is in place on the main campus.

- The 2012 Joint annual Report for Nashville Surgery Center indicates there were 4,126 surgical cases. Does the applicant expect to lose over 25% of the previous surgical volume at Nashville Surgery Center in the relocation?

  Response: No. There are providers other than Vanderbilt providers who practice at the Nashville Surgery Center. Only the Vanderbilt cases will be relocated to the main campus.

The projections of 38,600 surgical cases by FY17 at VUH as a result of the Nashville Surgery Center location and demand for surgical services are noted. Please indicate the average case per room in FY17 using the 38,600 surgical case projection.

Response: The average case per room used in FY17 will be approximately 700 cases.

7. **Section C, Need, Item 4.A. and 4.B.**

Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data **for each county** in your proposed service area.

Response: An attachment to the original application provides several of the demographic variables requested, including household income and median household age, on a county specific basis for the extensive service area which includes counties in Kentucky as well. A chart indicating TennCare enrollees as a percent of population is provided below for the Tennessee counties included in the extensive service area.

TN County	2013 Population*	2013 Median HH Income*	TennCare Enrollees (June 2013)**	TennCare Enrollees as % of Total**
Bedford	46,028	$35,847	10,670	0.9%
Cannon	13,706	$36,961	2,618	0.2%
Cheatham	39,028	$47,846	6,113	0.5%
Clay	7,638	$31,579	1,901	0.2%
Coffee	53,256	$36,082	11,097	0.9%
Cumberland	57,297	$33,147	10,349	0.9%
Davidson	645,722	$40,192	119,406	10.0%
DeKalb	19,002	$32,138	4,385	0.4%
Dickson	50,556	$37,026	8,855	0.7%
Fentress	18,086	$29,637	5,438	0.5%
Franklin	40,736	$39,243	6,304	0.5%
Giles	29,252	$31,864	5,253	0.4%
Grundy	13,350	$25,879	4,423	0.4%
Hickman	24,053	$42,321	5,248	0.4%
Houston	8,218	$34,201	1,699	0.1%
Humphreys	18,381	$36,265	3,504	0.3%
Jackson	11,046	$32,041	2,538	0.2%
Lawrence	42,385	$34,403	8,494	0.7%
Lewis	12,114	$35,045	2,558	0.2%
Lincoln	33,500	$41,089	6,269	0.5%
Macon	22,760	$28,824	5,890	0.5%
Marshall	31,183	$34,925	5,522	0.5%
Maury	82,133	$43,774	14,544	1.2%
Montgomery	181,674	$47,161	23,198	1.9%
Moore	6,467	$43,522	818	0.1%
Overton	22,263	$32,421	4,417	0.4%
Perry	7,874	$27,486	1,832	0.2%
Pickett	5,174	$30,596	984	0.1%
Putnam	73,688	$33,861	14,142	1.2%
Robertson	68,061	$50,092	10,988	0.9%
Rutherford	276,375	$47,362	36,196	3.0%
Smith	19,122	$33,347	3,673	0.3%
Stewart	13,014	$40,618	2,504	0.2%
Sumner	167,264	$44,284	22,935	1.9%
Trousdale	7,748	$42,358	1,702	0.1%
Van Buren	5,403	$27,311	1,157	0.1%
Warren	40,016	$29,798	9,232	0.8%
Wayne	16,859	$35,343	2,823	0.2%
White	26,506	$34,059	5,950	0.5%
Williamson	194,928	$83,220	8,343	0.7%
Wilson	119,707	$51,112	14,563	1.2%
41 County Total	2,571,573	$1,554,280	418,532	35.0%
State of TN			**1,194,908**	

*Source: © 2013 The Nielsen Company, © 2013 Truven Health Analytics Inc.

**Source: TN Bureau of TennCare

8. Section C, Need, Item 6

The chart of all 2009 inpatient and outpatient surgical volume in attachment C.Need.5 is noted. Please provide utilization and/or occupancy trends for each of the most recent three years of data available for this project.

Response: It is not practicable to provide the requested information on each of 68 surgical suites at Vanderbilt, both on and off campus; therefore, we are providing information as follows:

1. **A general description of the approach to scheduling and hours of operation for VUH surgeries.**
2. **A chart with surgical specialties and number of active surgeons**
3. **A chart showing the inpatient and outpatient surgical cases by specialty at VUH for recent prior years**
4. **Both charts provided have an estimated total for the two years after implementation of the project since projections of the number of surgeons and their respective specialties are dependent upon successful recruitment strategies.**

<u>General Description</u>
As a Level I trauma center, and as an institution with a burn center, transplant center and a robust Emergency Department, it must be recognized that case types and specialty uses vary by OR depending on the demand experienced at any given time.

For scheduling and operational planning purposes a block scheduling of operating rooms is typically employed. All surgical suites are anticipated to be open on a schedule of 7AM to 5PM or 7PM, depending on the specialty, Monday through Friday, as well as a subset of ORs that are open 24/7 365 days per year.

Once again, demand drives the use of operating rooms and some rooms are larger in order to accommodate the additional equipment needed for cases such as cardiovascular, neurological, transplant, and trauma cases. The VUH operating rooms vary from approximately 400 to approximately 1,200 square feet per room.

The proposed project provides additional capacity but does not alter the operational approach to surgeries at VUH.

Please identify the surgical specialties and the number of active surgeons, who currently operate in the surgical suite and the number which the applicant plans to add in the future.

Response: The chart provided portrays the surgical specialties and number of active surgeons at VUH for recent prior years. For the two years following project completion, an estimated total has been provided since the number of surgeons is dependent upon recruitment.

The HSDA is utilizing more detailed Historical and Projected Data Charts. Please complete the revised Projected Data Chart provided at the end of this request for supplemental information. Please note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company.

Response: There are no Management Fees to Affiliates or Non-Affiliates. The detail of the other expenses is provided below.

In addition, the Other Expense Category has been provided in detail below by the high level accounting categories that are available in the intuitional accounting system. These high level categories are compiled from hundreds of small expense categories.

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in July (Month).

		Year_____	Year_____
A.	Utilization Data (Specify unit of measure)	2,675	2,729
B.	Revenue from Services to Patients		
1.	Inpatient Services	$72,695,280	$74,162,774
2.	Outpatient Services	$35,092,393	$35,800,800
3.	Emergency Services	_____	_____
4.	Other Operating Revenue (Specify)_____	_____	_____
	Gross Operating Revenue	$107,787,673	$109,963,574
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$69,464,626	$70,866,903
2.	Provision for Charity Care	$6,882,847	$7,021,791
3.	Provisions for Bad Debt	$1,994,264	$2,034,522
	Total Deductions	$78,341,737	$79,923,215
NET OPERATING REVENUE		$29,445,936	$30,040,359
D.	Operating Expenses		
1.	Salaries and Wages	$5,329,333	$5,436,916
2.	Physician's Salaries and Wages	_____	_____
3.	Supplies	$6,996,465	$7,137,702

4.	Taxes	_____	_____
5.	Depreciation	$550,000	$550,000
6.	Rent	_____	_____
7.	Interest, other than Capital	_____	_____
8.	Management Fees:		
	a. Fees to Affiliates	_____	_____
	b. Fees to Non-Affiliates	_____	_____
9.	Other Expenses	$13,358,794	$13,628,467
	Total Operating Expenses	$26,234,593	$26,753,085
E.	Other Revenue (Expenses) -- Net (Specify)_____	$ 0	$ 0
NET OPERATING INCOME (LOSS)		$ 3,211,343	$3,287,273
F.	Capital Expenditures		
1.	Retirement of Principal	$_____	$_____
2.	Interest	_____	_____
	Total Capital Expenditures	**$_____**	**$_____**
		$ 3,211,343	$3,287,273

NET OPERATING INCOME (LOSS)
LESS CAPITAL EXPENDITURES

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES		**FY16**	**FY17**
1.	General & Administrative	$4,808,179	$4,905,242
2.	Fringe Benefits	$1,385,627	$1,413,598
3.	Interest	$1,249,781	$1,275,010
4.	Equipment Costs	$1,098,489	$1,120,665
5.	Laundry & Housekeeping	$678,998	$692,705
6.	Plant Operations	$358,642	$365,882
7.	Other	$3,779,078	$3,855,366
	Total Other Expenses	$13,358,794	$13,628,467

12. Section C, Economic Feasibility, Item 9

The applicant states 45% of Vanderbilt's revenue was Medicare, Medicaid, Bad Debt and Charity Care in FY 10-11 and FY 11-12. Please clarify why bad debt and charity care was classified as revenue.

Response: The categories in the chart each represent gross charges; therefore, 45% is the portion of charges for the services rendered to these categories of patients.

13. Section C, Contribution to the Orderly Development of Health Care, Item 2

Please provide a copy of the recent Blue Cross Blue Shield white paper that the applicant states evidences the in-migration to major referral centers from the outlying areas.

Response: Please see attached copy of the Blue Cross Blue Shield white paper.

14. Section C, Contribution to the Orderly Development of Health Care, Item 7 (d)

The Joint Commission survey dated April 27, 2012 is noted. Please clarify if this survey also included Nashville Surgery Center. If not, please attach the latest survey for Nashville Surgery Center.

Response: Nashville Surgery Center is a separate operating entity.

15. Section C, Contribution to the Orderly Development of Health Care, Item 8 and 9

The two questions apply to the applicant. Please respond in a manner other than "Not applicable".

Response:

Item 8:
Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

No such final orders or judgments exist.

Item 9:
Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project.

No such final civil or criminal judgments for fraud or theft exist.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is November 22, 2013. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates

	FY10	FY11	FY12	FY13	FY16	FY17
Bronch	12	15	17	16		
Cardiac	8	8	9	10		
ENT	17	22	25	24		
General	13	12	13	13		
GYN	21	29	32	29		
Hepatobiliary	4	4	5	4		
Neurosurgery	15	14	13	15		
Ophthalmology	17	17	17	17		
Oral Surgery	4	4	4	5		
Orthopaedics	28	30	28	29		
Other	1	1	4	5		
Plastics	8	8	8	9		
Renal	3	3	4	4		
Surg Onc	10	10	11	11		
Thoracic	4	4	4	4		
Trauma	15	16	16	13		
Urology	19	18	20	20		
Vascular	4	5	4	4		
Grand Total	203	220	234	232	240	242

Please provide the historical and projected number of cases by specialty.

Response: The chart provided on the following page (page 11) portrays the inpatient and outpatient surgical cases by specialty at VUH for recent prior years. For the two years following project completion, an estimated total has been provided.

	FY10	FY11	FY12	FY13	FY16	FY17
Bronch	**286**	**792**	**1005**	**1148**		
I	99	252	280	299		
O	187	540	725	849		
Cardiac	**1,194**	**1,018**	**1,234**	**1,274**		
I	1,192	1,016	1,229	1,268		
O	2	2	5	6		
ENT	**2,597**	**2,972**	**3,253**	**3,504**		
I	791	963	880	835		
O	1,806	2,009	2,373	2,669		
General	**2,266**	**2,417**	**2,494**	**2,439**		
I	1,195	1,258	1,270	1,277		
O	1,071	1,159	1,224	1,162		
GYN	**1,773**	**1,884**	**2,209**	**2,114**		
I	608	573	597	547		
O	1,165	1,311	1,612	1,567		
Hepatobiliary	**301**	**414**	**378**	**324**		
I	269	354	338	288		
O	32	60	40	36		
Neurosurgery	**2,474**	**2,655**	**2,691**	**2,839**		
I	1,943	2,112	2,098	2,215		
O	531	543	593	624		
Ophthalmology	**1,061**	**1,090**	**1,075**	**1,138**		
I	100	122	116	128		
O	961	968	959	1,010		
Oral Surgery	**566**	**634**	**606**	**523**		
I	290	309	261	272		
O	276	325	345	251		
Orthopaedics	**5,077**	**5,106**	**5,205**	**5,523**		
I	4,319	4,163	4,053	4,270		
O	758	943	1,152	1,253		
Other	**37**	**30**	**92**	**106**		
I	14	7	40	59		
O	23	23	52	47		
Plastics	**1,544**	**1,644**	**1,835**	**1,835**		
I	618	670	801	773		
O	926	974	1,034	1,062		
Renal	**510**	**555**	**619**	**602**		
I	239	275	310	313		
O	271	280	309	289		
Surg Onc	**1,675**	**1,878**	**2,003**	**2,302**		
I	515	534	535	600		
O	1,160	1,344	1,468	1,702		
Thoracic	**685**	**727**	**679**	**707**		
I	547	605	562	589		
O	138	122	117	118		
Trauma	**2,053**	**2,057**	**1,959**	**1,891**		
I	1,962	1,973	1,867	1,769		
O	91	84	92	122		
Urology	**3,294**	**3,183**	**3,630**	**3,551**		
I	1,546	1,438	1,364	1,317		
O	1,748	1,745	2,266	2,234		
Vascular	**947**	**1,135**	**1,117**	**1,106**		
I	576	710	688	638		
O	371	425	429	468		
Grand Total	**28,340**	**30,191**	**32,084**	**32,926**		
Vanderbilt Surgeons at Nashville Surgery Center						
O	2,944	2,704	2,885	3,021	-	-
Total VUH and NSC	**31,284**	**32,895**	**34,969**	**35,947**	**37,586**	**38,606**

Please provide the following information for VUH for the most recent year available.

Response: The chart below portrays only the main operating rooms and one other OR room at VUH. The one other OR room provides unique, specialized surgeries requiring bronchoscopic capabilities; this room is not what would routinely be referred to as a bronchoscopy suite. In addition, the chart was completed using only weekday cases (Monday through Friday).

	No. of VUH Main OR Rooms	Cases	Case per Room	Minutes Used	Average Turnaround Time	Schedulable minutes	% of Schedulable Time Used
Operating Rooms	50	30,091	601.82	5,058,603	42 mins	7,590,000	83.3%
Endoscopy Procedure Rooms							
Cystoscopy Rooms							
Other OR Room	1	1,146	48.99	56,146	20 mins	121,440	65.1%
Total Surgical Suite	51	31,237	n/a	5,114,749	n/a	7,711,440	n/a

Please provide the following for Nashville Surgery Center for the most recent year available:

Response: These data are not available as Vanderbilt is a minority owner.

	No. of Rooms	Procedures	Procedures / Room	Minutes Used	Average Turnaround Time	Schedulable minutes*	% of Schedulable Time Used
Operating Rooms							
Endoscopy Procedure Rooms							
Cystoscopy Rooms							
Other Procedure Rooms							
Total Surgical Suite							

* defined as the summation of the minutes by each room available for scheduled cases
Example: 7:30 AM to 4:30 PM, 5 days per week, 50 weeks/ year, equates to 9 hrs/day X 60 min/hr = 540 minutes/day X 5 days/week = 2,700 minutes / week X 50 weeks/year=135,000 schedulable minutes/room X the number of rooms=surgical suite schedulable capacity

9. Section C. Economic Feasibility Item 1 (Project Cost Chart)

Please provide documentation from a licensed architect or construction professional:

Response: See the attached letter from Vanderbilt University Medical Center Space and Facilities department describing the project and the fact that it will be managed to meet all applicable regulatory requirements.

1) a general description of the project,
2) his/her estimate of the cost to construct the project to provide a physical environment, according to applicable federal, state and local construction codes, standards, specifications, and requirements and
3) attesting that the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the new 2010 AIA Guidelines for Design and Construction of Hospital and Health Care Facilities.

Please break-out the cost of (4) anesthesia machines and (4) bariatric tables that total $1,219,427.36 in the Project Costs Chart.

Response: Please see the cost per anesthesia machine and bariatric table below.

Anesthesia Machine	**$95,000 each**
OR Table (which is capable of accommodating obese patients)	**$50,000 each**

10. Section C, Economic Feasibility, Item 3

Please compare the cost per square foot of construction to CN1307-028A, Saint Thomas Midtown Hospital f/k/a Baptist Hospital.

Response: The estimated cost per square foot of construction in CN1307-028A is $339 per square foot (or $303 excluding demolition); please see date stamped page 10 of the application. The estimated cost of this project ($475 per square foot) is higher due to the higher construction costs due to the extensive mechanical and electrical work demanded by this project.

11. Section C, Economic Feasibility, Item 4 (Historical Data Chart and Projected Data Chart)

Please clarify the reason there was a 34.5% increase in charity care from 2010 to 2012 while gross operating revenue only increased 20.5% during the same time period in the Historical Data chart.

Response: During the three fiscal years indicated in the chart, Vanderbilt has experienced an increase in self pay patients, an increase in bad debt expense (due to increased patient responsibility such as that in high deductible health plans), and an increase in denied claims.

Please discuss the impact the Affordable Care Act (ACA) will have on VUH's gross operating revenue and deductions from Operating Revenue for FY 2016 and FY 2017.

Response: Projections for the impact of sequestration, ACA, NIH funding are incorporated in future year projections for medical center operating revenue. The combined impacts are thought to result in the need to reduce $250 million from the budget over the next two fiscal years. Exact calculations on VUH gross operating revenue and deductions from revenue are not available given the uncertainty of the transformation of the healthcare industry and uncertainties regarding Tennessee participation in health exchanges and Medicaid expansion.

Please clarify why there are no expenses for physician's salaries and wages in the Projected Data Chart.

Response: Physicians at Vanderbilt are employed by the Vanderbilt Medical Group, a physician practice. As a consequence, physician salaries are not allocable to the project.

that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ɜ 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please contact this office.

Sincerely,

Phillip Earhart
HSD Examiner

Enclosure

September 26, 2013

Phillip Earhart
Health Services and Development Agency
Frost Building, 3rd Floor
161 Rosa L. Parks Blvd.
Nashville TN 37243

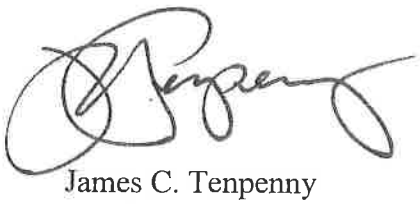
Re: CERTIFICATE OF NEED
THE VANDERBILT CLINIC 3RD FLOOR - 4 OR's

Dear Mr. Earhart:

This project will provide four additional OR's in TVC 3rd floor. Earl Swenson Associates, the architect, is working to complete construction documents which will conform to applicable federal, state, and local construction codes, standards, specification and requirements. We attest that this project will provide a physical environment which will conform to applicable federal standards, manufacturer's specifications, and licensing agencies' requirements, including the new 2010 AIA Guidelines for Design and Construction of Hospital and Health Care Facilities.

Turner Universal, the Construction Manager, has completed a conceptual estimate for this work and agrees that the construction budget is $4,326,482 and is appropriate, based on the conceptual design. A construction duration of seven months is expected to complete this work.

Sincerely,



James C. Tenpenny
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Cc: Ronald W. Hill, MPH

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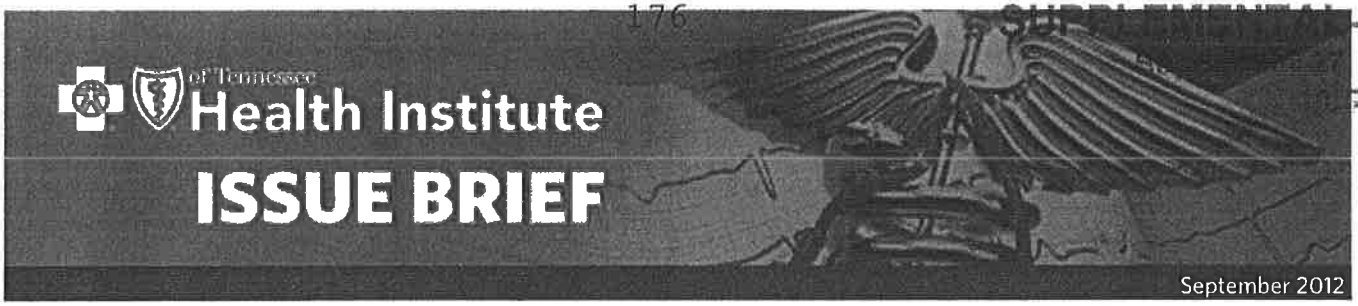

Steven L. Coulter, M.D.
BlueCross BlueShield of Tennessee Health Institute

Stephen G. Jones, Ph.D.
BlueCross BlueShield of Tennessee

J. Payne Carden
BlueCross BlueShield of Tennessee Health Institute

Patterns of Care in Tennessee

Use of rural vs. non-rural facilities

Previous research papers from the BlueCross BlueShield of Tennessee Health Institute have demonstrated a potential health care capacity crisis in Tennessee. In light of that, the Health Institute thought it important to examine actual patterns of care, such as where Tennesseans are going to obtain medical services. For this approach, our organization's research focused primarily — though not exclusively — on patterns of care for rural residents. The hypothesis in each case studied was that geographic proximity to a health care facility would have a statistically significant influence on a patient's ability to seek care. This hypothesis proved to be false.

The starting point: rural and non-rural care facilities

Starting with the Tennessee state list of licensed facilities, the pattern research first eliminated all specialty facilities from the study, such as psychiatric hospitals, rehabilitation hospitals, children's hospitals, and long-term care facilities for patients on respirators. This left 101 hospitals remaining, with those classified as either rural, small rural, urban, tertiary, or rural referral. For simplicity, these were regrouped as either rural (n=63) or non-rural (n=38).

Commercial data used from BlueCross BlueShield of Tennessee showed there were 60,414 hospital inpatient stays in those facilities in 2009. Of those, the data showed that 48,405 were by people living in Tennessee or in the state's contiguous counties. (Arriving at this figure was necessary to exclude those patients who come to our major teaching hospitals from out-of-state.)

Next, the study calculated the nearest facility on a straight-line basis for each of those stays.

Each stay was then categorized using the Diagnosis Related Groups (DRG) classification system, which groups inpatient stays based on similar diagnosis codes, severity, and patient demographics. After eliminating stays with an unknown DRG classification (e.g. M98, M99), 47,300 stays were retained for further analysis. Of those, 33,041 (69.9%) were not at the member's closest care facility.

An attempt was then made to compare apples to apples from the standpoint of medical services offered at competing non-rural facilities. In other words, it is not reasonable to say that a patient "chose" a non-rural hospital over a rural one if the service he or she needed (e.g. a coronary bypass) was not available at the closer facility. This methodology left 20,536 people (43.4%) who made a *choice* to "migrate." Since the research examined the DRG claims actually submitted by each rural facility, the assumption was made that a service was not offered by a facility if there had been no claims submitted by that facility for that DRG in 2009. Therefore, this method may

understate the actual range of services offered by a rural hospital, and in turn would make the estimates of the number of rural people leaving their area conservative ones.

Those rural members, defined as those whose closest facility was a rural facility, willingly migrated and chose a facility that was, on average, 22.6 miles farther away than their closest facility. For those who are interested, there is a more complete discussion of methodology in the appendix.

What do the numbers show?

In simple terms, almost half of the people in rural areas are not using the hospital closest to them, preferring to go to a larger, non-rural hospital to get care, *even if the same services are available locally*.

Proximity vs. mobility

Distance may not be a barrier in today's mobile culture. When most of the state's rural hospitals were established, transportation was much more difficult than it is today, particularly when transporting severely ill patients. Transportation capability has changed from a family member with a station wagon, who sped to the closest emergency room, to a rapid-response helicopter that can travel any direction, begin effective treatment in-flight, and evacuate the patient to larger, more distant facilities in mere minutes.

Technology vs. investment capital

Additionally, when most rural hospitals were established, their service capabilities were similar to those provided by facilities in more urban locations. All of that has changed with the explosion in technology in the medical care industry. Effective hospitals are typically highly capital intensive, and often, the rural facilities just don't have the money to keep up. While some rural facilities have maintained an adequate patient base to be financially viable, others have not.

Capacity vs. costs

But then, what about capacity? Do the urban referral centers have the capacity to take on the additional patients? All large hospitals in the state have far more licensed beds than staffed beds. That means, simply put, that they have beds already on their fixed cost base, and they could staff up those beds by incurring only variable (staffing) costs.

Preventive care and treatment choices

In addition to examining the numbers for inpatient stays, pattern examples from both preventive care and treatment of a medical condition were explored. The examples studied could serve to give a better view of how the health care delivery system could be structured, since these tests involve patient choice and elective care situations. The geographical correlation analysis of the delivery system could also provide insight into how providers and patients interact — and whether geographic barriers of access still exist in today's mobile world.

1. The preventive care analysis first examined a commonly studied interaction between access to a mammogram facility and the likelihood of women being adherent with recommended breast cancer screenings. The analysis included nearly 23,000 female patients insured by BlueCross BlueShield of Tennessee with ages ranging from 42 to 69. Of these women, 53% were past due to receive their recommended breast cancer

screening. From supplied home address information, the patients' residential locations were mapped using a geographic information system. The 196 accredited mammography facilities in Tennessee were mapped, as well. Then, a statistical model was constructed to determine if distance from the home to the nearest facility had any influence on adherence with the screening, while controlling for other factors, such as race, age and socio-economic status.

What do the numbers show?

Results suggest that distance had no influence. In fact, the average distance from a member's residence to the nearest mammography facility was almost identical for adherent patients (4.77 ± 0.04 miles) versus non-adherent patients (4.76 ± 0.04 miles). In other words, a patient's proximity to a mammography facility does not predict that they are more likely to be compliant with the Centers for Disease Control's preventive guidelines for mammography screening.

2. For a treatment measure, since low-back pain is one of the three most common non-obstetrical diagnoses treated in Tennessee hospitals, analysis further examined the likelihood that a patient diagnosed with low-back pain would have surgery. (The appropriateness of surgery was not a part of the analysis — just whether surgery occurred, since that indicates access to a surgical facility). Just as before, the analysis mapped the patients with a clinical diagnosis of low-back pain (n=6152), and employed a balanced design containing 3,076 patients who had back surgery following their diagnosis and 3,076 patients who did not have back surgery following their diagnosis. Again, the study was controlled for various socio-economic and health status factors. Access to chiropractors, surgeons or surgery facilities had no influence on whether low-back pain patients ended up in surgery.

What do the numbers show?

Results show that 2% of non-rural members had surgery, compared to 6% of rural members – a difference that is not statistically significant.

Note that this method could potentially understate the difference between rural and non-rural residents in that it requires at least an initial consultation with a physician. It is possible that some rural (or urban) residents with back pain did not seek *any* medical care, in which case they would not be included in the study. However, once patients accessed the care system, geography did not prove to be a barrier to receiving surgery.

What can be seen in these patterns of care

As seen by these examples, research results on patterns of care suggest that:

- Location within the measured parameters (i.e. rural vs. non-rural) does not significantly influence the patients' ability to receive care.
- In many cases, rural residents are choosing to receive care farther from their home.
- While rural patients did drive farther for inpatient care, they were not less likely to be compliant with preventive care recommendations when compared to their urban counterparts.
- Rural and urban patients also received treatment for existing conditions at the same rate as seen in the back surgery study.

With patients becoming more mobile, it appears they are more likely to seek care anywhere and at their own convenience. This could spell trouble for smaller, rural facilities. With more than 43% of rural patients choosing to drive by their nearest facility in order to receive care at larger, more distant facilities, it may be difficult for these rural hospitals to remain solvent.

A limitation of this study is that the data are all from BlueCross BlueShield of Tennessee commercial membership. Therefore, it would be inappropriate to draw conclusions about other populations such as the uninsured, TennCare members or Medicare beneficiaries.

It should be noted that this study did not examine the impact that rural facilities have on their communities, either from a clinical or economic standpoint. A hospital can employ many people who live, shop, spend and pay taxes within a community. It can also bring in revenue from outside the community through federal programs such as Medicare, state programs such as Medicaid, and from commercial insurance. The study also did not take into account the clinical consequences of closing a rural facility. There are medical situations and disease conditions for which minutes count — coronary artery disease and acute myocardial infarction, for example.

When examining voluntary choices and the effects of consumer behavior on the health care delivery system, more needs to be studied before any conclusions can be drawn regarding the viability of small or rural hospitals. Questions such as these deserve further analysis and elaboration.

- Is it to be expected that rural hospitals seek to maintain a competitive set of surgical services and capabilities, compared to their urban counterparts?
- What are the factors that patients consider in making their choices in hospital and treatment care?
- If a small hospital closed its doors — and nothing replaced it — what would be the clinical consequences for the local citizens?
- If a small hospital closed its doors — and nothing replaced it — what would be the economic consequences for the community and the local citizens?
- Is it time to review policies that subsidize with tax dollars those facilities that cannot make it on their own? ❖

About the BlueCross BlueShield of Tennessee Health Institute

The BlueCross BlueShield of Tennessee Health Institute was established with the goal of becoming the premier source of information about health care for Tennessee decision makers.

It is committed to providing a fact-based intellectual framework that will contribute to the public discussion on health care and policy development. When possible, the Health Institute will articulate with data the likely implications of health care policy changes on the local market in Tennessee. The mission is to inform interested parties about emerging trends through extensive research and analysis and to become a trusted source for reliable insights.

Appendix

Methodology used to analyze a member's willingness to migrate

Using the commercial claims data warehouse of BlueCross BlueShield of Tennessee, the research extracted all inpatient stays having either an admission or discharge date during the 2009 time period (n = 151,845). Only inpatient stays where the member was age 21 - 75 at the time of service (n= 97,830) were retained. The length of stay was adjusted to only capture the number of stay days occurring in 2009. Using the list of hospital facilities provided by the Tennessee Department of Health, Division of Health Statistics, the facilities were data mapped to the inpatient stay data by cross-referencing the National Provider Indicator (NPI) value. Then all specialty facilities and therefore inpatient stays at psychiatric hospitals, rehab hospitals, children's hospitals, and long-term care facilities were eliminated. Only inpatient stays where the member lived inside Tennessee or a surrounding county (n = 48,405) were retained.

For all distance calculations, the research calculated Euclidean (i.e., straight-line) distance values. Previous work in this area has shown a significantly high correlation between Euclidean distance and drive-time distances within Tennessee and associated inpatient stay data (Jones SG, Ashby AJ, Momin SR, Naidoo A. Spatial Implications Associated with using Euclidean Measurements and Zip Code Centroid Geoimputation Methods in Healthcare Research. 2010. Health Services Research, 45(1):316-327). Distances were calculated from each member to their closest facility, as well as to their admitting facility (note: in some cases, these facilities were the same). If the member's inpatient stay was at a location other than their closest facility, this member was defined as "migrating." Members closest to a rural facility were defined as rural members. Note that distance calculations accounted for the curvature of the earth where:

Distance = 3956 * (2 * arsin(min(1, sqrt((sin(((member_latitude - facility_latitude) * constant('pi')/180)/2)**2) + ((cos(facility_latitude * constant('pi')/180)) * (cos(member_latitude * constant('pi')/180)) * (sin(((member_longitude - facility_longitude) * constant('pi')/180)/2)**2))))))

To determine if migrations were voluntary, the reason for the member's stay was evaluated via the Diagnosis Related Group coding system. Using four years of prior inpatient claims data (2005-2008) from BlueCross BlueShield of Tennessee, DRGs were evaluated for all inpatient stays for all facilities in order to build a reference table. This reference table contained information on all the DRGs that were performed at the facility in question during the look-back period. The assumption was that if a DRG previously occurred at a facility, then this facility is capable of performing the service. If a member migrated beyond their nearby facility and the admitting DRG had been previously performed at their nearby facility, then this stay was defined as a "voluntary migration." This means the patient willingly chose services elsewhere, even though those services could have been performed locally. Frequency tables were constructed in SAS® statistical analysis software to examine the percentage of voluntary and involuntary migrations for rural and non-rural members. Confidence limits (95%) were also constructed though not reported in this brief.

COPY-

SUPPLEMENTAL-2

Vanderbilt University Hospitals

CN1309-034

1. Section B, Project Description, Item 1

In the Project Costs Chart, four (4) bariatric tables are listed as moveable equipment. Please clarify if the requested operating rooms will be primarily used for bariatric patients. If not, what type of patients will use the requested four (4) ORs? Please provide a projection of surgical cases by specialty in the four (4) operating rooms.

Response: The OR tables listed are rated as bariatric tables due to the need to have maximum flexibility in managing obese patients for any service. A variety of surgical cases will be performed in these ORs to include bariatric surgeries. Equipping the four ORs with this level of equipment allows for maximum utilization of the operating rooms. Vanderbilt no longer purchases operating room tables that do not meet obese patient weight bearing design standards.

The operating rooms at VUH are typically in use on an as needed basis and the distribution of cases to rooms occurs on a daily (or even more frequent) basis. Therefore, we have not assigned specialties to specific rooms. Nevertheless, we anticipate that the preponderance of the cases to occupy the rooms will be in the following specialties: general surgery, surgical oncology, and urology. (Prior year inpatient and outpatient volume by specialty for all specialties has been provided in the first supplemental response.) It should be noted that anticipated growth in surgical volume will occur across specialties other than those identified above and the projected growth requires the new operating rooms in order to handle the increasing demand.

2. **Section C, Need, Item 6**

The chart of all 2009 inpatient and outpatient surgical volume in attachment C.Need.5 is noted. As previously requested, please provide utilization and/or occupancy trends for each of the most recent three years of data available for this project. A copy of the attachment is enclosed.

Response: Attached are 2010 and 2011 inpatient and outpatient surgical volumes experienced at area hospitals. These data are from the same source as the 2009 data previously provided. The data were obtained from the Tennessee Department of Health, Division of Health Statistics and represent the most recent summary data available from that office.

The inpatient and outpatient surgical volumes for all VUH surgical specialties over a four year period (FY10-FY13) were provided in the first supplemental response. The data below are extracted from that source and are specific to the specialties identified in the response to Question #1. Recall that even though these specialties are singled out, they will not be uniquely performed in the new rooms. Growth in other surgical specialties will require distribution of the new cases among many operating rooms. For the same reason, there are no prior occupancy trends for the new rooms.

	FY10	FY11	FY12	FY13
Inpatient	1,195	1,258	1,270	1,277
Outpatient	1,071	1,159	1,224	1,162
General Surgery	**2,266**	**2,417**	**2,494**	**2,439**
Inpatient	515	534	535	600
Outpatient	1,160	1,344	1,468	1,702
Surgical Oncology	**1,675**	**1,878**	**2,003**	**2,302**
Inpatient	1,546	1,438	1,364	1,317
Outpatient	1,748	1,745	2,266	2,234
Urology	**3,294**	**3,183**	**3,630**	**3,551**

The response to the request to provide information regarding the Vanderbilt surgical suites is noted. However, the intent of the question was to determine if there are any existing operating rooms being underutilized or possibly not in use at Vanderbilt, either inpatient or outpatient. If possible, please provide a range from the lowest to the highest of the % of scheduled time used in the existing ORs at Vanderbilt.

Response: There are no VUH existing operating rooms underutilized and, with the exception of a room occasionally out of service for renovation or upgrade, there are no operating rooms not in use. The annual budget for the operating rooms is developed with the assumption of staffing all rooms.

A chart in the response to the first set of supplemental questions indicated an 83.3% average utilization of 50 operating rooms using the method of calculation provided. One operating room, separately identified, had a utilization of 65.1% due to the fact that it is typically used for highly specialized interventional brochoscopic surgeries. The latter room can be considered to represent the lowest utilization percent of scheduled time and most rooms can be considered to achieve at least as high as the 83.3% average utilization with some rooms utilized at a higher rate in order to produce the 83.3% average.

2010 Joint Annual Report of Hospitals
Schedule D - Page 12

ID	Hospital	County	Surgery: Inpatient Service Provided	Inpatient Encounters	Inpatient # O.R.'s	Inpatient Procedures	Surgery: Outpatient Service Provided	Outpatient Encounters	Outpatient # Dedicated O.R.'s	Outpatient Procedures
02214	Heritage Medical Center	Bedford	Yes	0	3	0	Yes	1,738	0	1,194
08214	Stones River Hospital	Cannon	Yes	165	2	194	Yes	634	1	146
11204	Centennial Medical Center at Ashland City	Cheatham	No	0	0	0	Yes	146	0	0
14204	Cumberland River Hospital	Clay	No	0	0	0	No	0	0	0
16214	United Regional Medical Center	Coffee	Yes	162	2	174	Yes	1,328	3	1,426
16234	Harton Regional Medical Center	Coffee	Yes	2,210	5	2,322	Yes	4,525	2	5,576
16244	Medical Center of Manchester	Coffee	Yes	234	2	252	Yes	493	2	541
18224	Cumberland Medical Center	Cumberland	Yes	1,472	9	2,934	No	2,690	0	4,669
19214	Southern Hills Medical Center	Davidson	Yes	969	10	1,246	Yes	2,344	10	4,692
19234	Skyline Medical Center Campus	Davidson	No	0	0	0	No	0	0	0
19244	Metro Nashville General Hospital	Davidson	Yes	1,629	9	1,785	Yes	2,438	0	2,593
19254	Baptist Hospital	Davidson	Yes	6,253	26	21,268	Yes	8,291	0	15,129
19274	Saint Thomas Hospital	Davidson	Yes	7,624	18	27,175	Yes	3,084	2	5,852
19284	Vanderbilt University Hospitals	Davidson	Yes	21,633	61	43,346	Yes	23,674	6	39,399
19324	Centennial Medical Center	Davidson	Yes	7,131	33	9,939	Yes	3,858	4	4,566
19334	Skyline Medical Center	Davidson	Yes	2,266	12	0	Yes	2,906	0	0
19344	Summit Medical Center	Davidson	Yes	1,988	0	2,195	Yes	3,515	0	4,167
19354	The Center for Spinal Surgery	Davidson	Yes	1,273	6	1,273	Yes	2,200	0	2,200
19404	Middle Tennessee Mental Health Institute	Davidson	No	0	0	0	No	0	0	0
19754	Kindred Hospital - Nashville	Davidson	No	0	0	0	No	0	0	0
19764	Vanderbilt Stallworth Rehabilitation Hospital	Davidson	No	0	0	0	No	0	0	0
19784	Select Specialty Hospital - Nashville	Davidson	No	0	0	0	No	0	0	0
21234	DeKalb Community Hospital	DeKalb	Yes	141	3	158	Yes	1,439	0	1,574
22204	Horizon Medical Center	Dickson	Yes	1,417	7	2,834	Yes	3,018	0	4,225
25204	Jamestown Regional Medical Center	Fentress	Yes	0	2	287	Yes	0	1	402
26204	Emerald - Hodgson Hospital	Franklin	No	0	0	0	No	0	0	0
26224	Southern Tennessee Medical Center	Franklin	Yes	964	6	964	Yes	2,180	0	2,180
28214	Hillside Hospital	Giles	Yes	388	4	407	Yes	1,567	0	1,768
41214	Hickman Community Hospital	Hickman	No	0	0	0	No	0	0	0
42204	Patients' Choice Medical center of Erin	Houston	Yes	0	3	0	Yes	56	0	56
43204	Three Rivers Hospital	Humphreys	Yes	1	2	1		50	0	60
50234	Crockett Hospital	Lawrence	Yes	642	6	642	Yes	1,688	0	1,688
52214	Lincoln Medical Center	Lincoln	Yes	295	2	295	Yes	719	0	719
56204	Macon County General Hospital	Macon	Yes	10	1	14	Yes	337	1	352
59244	Marshall Medical Center	Marshall	Yes	23	2	32	Yes	438	0	499
60224	Maury Regional Hospital	Maury	Yes	3,442	11	6,591	Yes	4,833	2	8,282
63204	Gateway Medical Center	Montgomery	Yes	2,116	12	2,571	Yes	4,144	0	4,979
63404	Behavioral Healthcare Center at Clarksville	Montgomery	No	0	0	0	No	0	0	0
67214	Livingston Regional Hospital	Overton	Yes	521	3	521	Yes	1,630	4	1,630
68204	Perry Community Hospital	Perry	Yes	3	1	3	Yes	98	1	98
71204	Cookeville Regional Medical Center	Putnam	Yes	2,827	10	4,131	Yes	6,153	0	8,074
74214	NorthCrest Medical Center	Robertson	Yes	906	5	1,107	Yes	4,092	0	5,243
75214	Middle Tennessee Medical Center	Rutherford	Yes	3,177	10	0	Yes	4,326	0	0
75234	StoneCrest Medical Center	Rutherford	Yes	1,644	7	1,644	Yes	4,211	0	4,211
80204	Riverview Regional Medical Center North	Smith	Yes	178	2	178	Yes	780	1	780
80214	Riverview Regional Medical Center South	Smith	No	0	0	0	No	0	0	0
83204	Portland Medical Center	Sumner	No	0	0	0	No	0	0	0
83244	Sumner Regional Medical Center	Sumner	Yes	1,713	7	12,555	Yes	3,373	0	3,945
83254	Hendersonville Medical Center	Sumner	Yes	1,538	8	8,217	Yes	6,127	0	13,719
85214	Trousdale Medical Center	Trousdale	Yes	5	1	19	Yes	21	1	22
89234	River Park Hospital	Warren	Yes	570	4	780	Yes	1,477	2	2,115
91214	Wayne Medical Center	Wayne	Yes	9	1	9	No	0	0	0
93204	White County Community Hospital	White	Yes	306	2	306	Yes	1,211	1	1,211
94234	Williamson Medical Center	Williamson	Yes	3,010	11	3,109	Yes	3,813	0	3,862
94804	Rolling Hills Hospital	Williamson	No	0	0	0	No	0	0	0
95204	McFarland Hospital	Wilson	No	0	0	0	No	0	0	0
95224	University Medical Center	Wilson	Yes	2,368	4	2,596	Yes	5,147	4	5,646

2011 Joint Annual Report of Hospitals
Schedule D - Page 12

ID	Hospital	County	Inpatient				Surgery			
			Service Provided	Encounters	# O.R.'s	Procedures	Service Provided	Inpatient Encounters	# Dedicated O.R.'s	Inpatient Procedures
02214	Heritage Medical Center	Bedford	No	0	3	0	Yes	2349		
08214	Stones River Hospital	Cannon	Yes	128	2	165	Yes	490	0	868
11204	Centennial Medical Center at Ashland City	Cheatham	No	0	0	0	Yes	130	1	142
14204	Cumberland River Hospital	Clay	No	0	0	0	Yes	0	0	0
16214	United Regional Medical Center	Coffee	Yes	90	2	123	Yes	533	3	1106
16234	Harton Regional Medical Center	Coffee	Yes	2223	7	2545	Yes	5816	2	6717
16244	Medical Center of Manchester	Coffee	Yes	222	2	257	Yes	492	2	572
18224	Cumberland Medical Center	Cumberland	Yes	1283	9	2497	Yes	2693	0	4946
19214	Southern Hills Medical Center	Davidson	Yes	883	10	1068	Yes	2275	10	2657
19234	Skyline Medical Center Campus	Davidson	No	0	0	0	No	0	0	0
19244	Metro Nashville General Hospital	Davidson	Yes	1645	9	1836	Yes	2716	0	3008
19254	Baptist Hospital	Davidson	Yes	9387	26	22875	Yes	7601	2	14319
19274	Saint Thomas Hospital	Davidson	Yes	7662	18	25978	Yes	3580	2	6574
19284	Vanderbilt University Hospitals	Davidson	Yes	22242	62	46436	Yes	25631	5	43705
19324	Centennial Medical Center	Davidson	Yes	7377	37	10964	Yes	10817	0	16456
19334	Skyline Medical Center	Davidson	Yes	2113	12	2141	Yes	2769	0	2748
19344	Summit Medical Center	Davidson	Yes	2455	12	2611	Yes	2932	0	3525
19354	The Center for Spinal Surgery	Davidson	Yes	1127	6	1127	Yes	2336	0	2336
19404	Middle Tennessee Mental Health Institute	Davidson	No	0	0	0	No	0	0	0
19754	Kindred Hospital - Nashville	Davidson	No	0	0	0	No	0	0	0
19764	Vanderbilt Stallworth Rehabilitation Hospital	Davidson	No	0	0	0	No	0	0	0
19784	Select Specialty Hospital - Nashville	Davidson	No	0	0	0	No	0	0	0
21234	DeKalb Community Hospital	DeKalb	Yes	118	3	118	Yes	1142	0	1171
22204	Horizon Medical Center	Dickson	Yes	1381	7	2762	Yes	3020	0	4228
25204	Jamestown Regional Medical Center	Fentress	Yes	0	2	140	Yes	0	0	853
26204	Emerald - Hodgson Hospital	Franklin	No	0	0	0	No	0	0	0
26224	Southern Tennessee Medical Center	Franklin	Yes	865	6	865	Yes	2018	0	2018
28214	Hillside Hospital	Giles	Yes	188	4	197	Yes	1250	0	1388
41214	Hickman Community Hospital	Hickman	No	0	1	0	Yes	276	1	276
42204	Patients' Choice Medical Center of Erin	Houston	Yes	0	3	0	Yes	48	0	48
43204	Three Rivers Hospital	Humphreys	Yes	2	2	3	Yes	45	0	53
50234	Crockett Hospital	Lawrence	Yes	307	6	307	Yes	791	0	761
52214	Lincoln Medical Center	Lincoln	Yes	292	2	292	Yes	770	0	770
56204	Macon County General Hospital	Macon	No	27	1	35	Yes	697	1	733
59244	Marshall Medical Center	Marshall	Yes	3	2	4	Yes	358	0	422
60224	Maury Regional Hospital	Maury	Yes	3626	11	6910	Yes	4451	2	7522
60404	Behavioral Healthcare Center at Columbia	Maury	No	0	0	0	No	0	0	0
63204	Gateway Medical Center	Montgomery	Yes	2088	12	2242	Yes	4189	0	4587
63404	Behavioral Healthcare Center at Clarksville	Montgomery	No	0	0	0	No	0	0	0
67214	Livingston Regional Hospital	Overton	Yes	374	3	374	Yes	1578	4	1578
68204	Perry Community Hospital	Perry	No	0		0	Yes	73	1	73
71204	Cookeville Regional Medical Center	Putnam	Yes	2941	10	4197	Yes	6664	0	7220
74214	Northcrest Medical Center	Robertson	Yes	824	5	906	Yes	4268		4908
75214	Middle Tennessee Medical Center	Rutherford	Yes	4152	12	8922	Yes	3927	0	6625
75234	StoneCrest Medical Center	Rutherford	Yes	1630	7	1630	Yes	4350	0	4350
80204	Riverview Regional Medical Center North	Smith	Yes	161	2	161	Yes	749	1	749
80214	Riverview Regional Medical Center South	Smith	No	0	0	0	No	0	0	0
83204	Portland Medical Center	Sumner	No	0	0	0	No	0	0	0
83244	Sumner Regional Medical Center	Sumner	Yes	1879	6	1879	Yes	3007	0	3007
83254	Hendersonville Medical Center	Sumner	Yes	1177	8	2858	Yes	2779	0	5106
85214	Trousdale Medical Center	Trousdale	No	0	0	0	No	0	0	0
89234	River Park Hospital	Warren	Yes	545	4	701	Yes	1129	2	1712
91214	Wayne Medical Center	Wayne	Yes	0	1	0	No	0	0	4
93204	White County Community Hospital	White	Yes	295	2	295	Yes	1165	1	1165
94234	Williamson Medical Center	Williamson	Yes	2940	11	3156	Yes	4028	0	4176
94804	Rolling Hills Hospital	Williamson	No	0	0	0	No	0	0	0
95204	McFarland Hospital	Wilson	No	0	0	0	No	0	0	0
95224	University Medical Center	Wilson	Yes	2398	4	2435	Yes	5212	4	5518

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Davidson

NAME OF FACILITY: Vanderbilt University Hospitals

I, Ronald W. Hill, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Ronald W. Hill
VICE PRESIDENT, BUSINESS DEVELOPMENT

Sworn to and subscribed before me, a Notary Public, this the 27th day of September, 2013, witness my hand at office in the County of Davidson, State of Tennessee.

Jennifer Hygrell
NOTARY PUBLIC

My commission expires May 5, 2015.

JENNIFER HYGRELL
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON

HF-0043

Revised 7/02

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LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Tennessean (Name of Newspaper) which is a newspaper of general circulation in Davidson (County), Tennessee, on or before September 13 (Month / day), 2013 (Year) for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency,

Vanderbilt University Hospitals (Name of Applicant) an existing acute care hospital (Facility Type-Existing)

owned by: Vanderbilt University with an ownership type of not-for-profit

and to be managed by: Vanderbilt University Hospitals intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]:

the expansion and renovation to the existing third floor operating suite by four operating rooms and by providing shell space for future expansion of two additional operating rooms at 1211 Medical Center Drive, Nashville, TN. Project costs include the four new operating rooms and associated equipment costs. The estimated project cost is $7,535,708.64. No major medical equipment will be involved. The total number of licensed beds will not change as a result of this project.

The anticipated date of filing the application is: September 13, 2013

The contact person for this project is Ronald W. Hill (Contact Name), Vice President, Business Development (Title)

who may be reached at: Vanderbilt University Medical Center (Company Name), 3319 West End Avenue, Suite 920 (Address)

Nashville (City), TN (State), 37203 (Zip Code), 615-936-6012 (Area Code / Phone Number)

Ronald W. Hill (Signature), 9/9/13 (Date), ron.hill@vanderbilt.edu (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
The Frost Building, Third Floor
161 Rosa L. Parks Boulevard
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

CERTIFICATE OF NEED
REVIEWED BY THE DEPARTMENT OF HEALTH
DIVISION OF POLICY, PLANNING, AND ASSESSMENT
615-741-1954

DATE: November 27, 2013

APPLICANT: Vanderbilt University Hospitals
1211 Medical Drive
Nashville, Tennessee 37232

CON#: CN#1309-034

CONTACT PERSON: Ron Hill, Vice President Business Development
Vanderbilt University Hospitals
3319 West End Avenue, Suite 920
Nashville, Tennessee 37203

COST: $7,535,708.64

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Policy, Planning, and Assessment, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's State Health Plan*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

SUMMARY:
The applicant, Vanderbilt University Hospitals (VUH), located in Nashville (Davidson County), Tennessee, seeks Certificate of Need (CON) approval for the expansion and renovation to the existing third floor operating suite by the addition of four operating rooms and by providing shell space for future expansion of two additional operating rooms at 1211 Medical Center Drive. The project does not involve major medical equipment and the licensed bed compliment will not change.

The proposed four operating rooms range between 595 square feet and 616 square feet with future shell space measuring 2,739 square feet. Additionally, a clean corridor (1,189 square feet) and support space (902 square feet) are included in the project. The total project consists of 9,108 square feet, which includes 751 square feet of mechanical space and 1,092 square feet of circulation space. The total construction cost is $4,326,482 or $475.02 per square foot. The estimated cost per square foot is higher than the most recent comparable project, Saint Thomas Midtown f/k/a Baptist Hospital's (CN1307-028A) cost of $309 per square foot (excluding demolition). The applicant cites higher construction costs due to extensive mechanical and electrical work demanded by this project as the cause of the increased cost per square foot.

Vanderbilt University, by and through its Vanderbilt Medical Center, owns Vanderbilt University Hospital facilities. The applicant provides an organizational chart in Attachment A.4.

The total estimated project cost is $7,535,708.64 and will be funded through cash reserves as attested to by a letter from the Interim Senior Vice President of Finance, Vanderbilt University Medical Center, in Attachment C. Economic Feasibility 2.E.

GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

NEED:

The applicant proposes this project as a consequence of currently high surgical volumes as well as future anticipated growth due to patients seeking subspecialty surgical care available at Vanderbilt. The applicant reports there were approximately 30,645 adult surgical cases at Vanderbilt in FY2013. Surgical volumes over the last three years have experienced substantial growth. The applicant reports growth rates ranging between 3% for inpatient cases and 12% for outpatient cases over the last several years. However, the applicant used a conservative growth rate of 3% for this project. Additionally, the Vanderbilt surgical case volume currently performed at the Nashville Surgery Center will be relocated to Vanderbilt in October 2014, resulting in approximately 3,000 additional cases. (The applicant is a 40% minority owner in Nashville Surgery Center). VUH is projecting 38,600 surgical cases by 2017.

In Supplemental 1, the applicant provides a chart with total cases, cases by room, minutes used, average turnaround, schedulable minutes and percentage of schedulable minutes used for 50 main operating rooms and 1 other OR room. The main operating rooms used 83.3% of schedulable minutes and the other OR used 65.1% of schedulable minutes. In addition, the applicant provides cases by specialty for years FY2010 through FY2013 in Supplement 1.

The applicant reported the following inpatient and outpatient surgical procedures to the *Joint Annual Report of Hospitals for 2009, 2010, and 2011.*

Vanderbilt University Hospital Surgical Room Procedures

	2009 Inpatient Procedures	2009 Outpatient Procedures	2010 Inpatient Procedures	2010 Outpatient Procedures	2011 Inpatient Procedures	2011 Outpatient Procedures
Vanderbilt University Hospital	40,462	30,627	43,346	39,399	46,436	43,705

Source: *Joint Annual Report of Hospitals 2009, 2010, 2011,* Tennessee Department of Health, Division of Policy, Planning, and Assessment

The applicant's inpatient and outpatient surgical procedure volume increased each year as reported in the Joint Annual Report. From 2009 through 2011, inpatient procedures increased 7.1% and outpatient procedures increased 10.9%.

The applicant reports 54% of VUH's surgical patients were TennCare/Medicaid, Medicare, and uninsured patients. VUH provides services to all consumers regardless of race, gender, ethnicity or income. Many programs, such as multi-language translation capabilities are implemented to assure ease of access. In addition, VUH participates in several programs in conjunction with Meharry Medical Center that specifically research and address disparities in health outcomes associated with minority populations.

TENNCARE/MEDICARE ACCESS:
The applicant participates in Medicare and TennCare/Medicaid programs. In Attachment A.13, the applicant provides a listing of all MCO's they have contracts with MCO's.

In FY2011-12, the applicant reports a payor mix of 20% Medicare and 18% Medicaid. In FY 2015-16, the applicant projects a payor mix of 40% Medicare and 7% TennCare/Medicaid.

ECONOMIC FACTORS/FINANCIAL FEASIBILITY:
The Department of Health, Division of Policy, Planning, and Assessment has reviewed the Project Costs Chart, the Historical Data Chart, and the Projected Data Chart to determine if they are mathematically accurate and the projections are based on the applicant's anticipated level of utilization. The location of these charts may be found in the following specific locations in the Certificate of Need Application or the Supplemental material:

Project Costs Chart: The Project Costs Chart is located on page 13 of the application. The total project cost is estimated to be $7,535,708.64.

Historical Data Chart: The Historical Data Chart is located on pages 15-16 of the application. The applicant reports net operating income of $91,282,396, $103,795,178, and $104,181,348 in years 2010, 2011, and 2012, respectively.

Projected Data Chart: The Projected Data Chart located is in Supplemental 1, pages 14 and 15. The applicant projects 2,675 and 2,729 cases in years one and two with net operating revenues of $3,211,343 and $3,287,273 each year respectively.

The average gross charge in year one is projected to be $40,294, with an average deduction of $29,286, resulting in an average net charge of $11,008.

The applicant did not consider any other alternative to this proposed project because the project is adjacent to all the major resources committed to surgical care at VUH.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:
The applicant provides a listing of all health care providers, managed care organizations, alliances, networks, etc. in Attachment C. Contribution to the Orderly Development of Healthcare.1.

The proposed project will improve access to care by allowing Vanderbilt to expand capacity to the subspecialty surgical care market. The applicant provides a recent Blue Cross Blue Shield of Tennessee white paper providing evidence of the in-migration to major referral centers from outlying areas. Vanderbilt has a complete array of surgical subspecialties available.

The proposed staffing for the project includes 9.4 FTE registered nurses, 5.6 FTE surgical technologists, and 2.0 FTE facility administrators.

Vanderbilt has accredited training programs in medicine, radiation oncology, medical physicists and dosimetrists, nursing, pharmacy, respiratory therapy, dietetics, medical technology, radiation therapy, cardiovascular perfusion technology, and nuclear medicine. Vanderbilt is also a major clinical training facility for Vanderbilt Medical and Nursing Schools. Vanderbilt has a total house staff training program of 697 residents and 279 fellows.

Vanderbilt is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities and is accredited by The Joint Committee.

SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

2. For relocation or replacement of an existing licensed health care institution:

   a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

      This criterion is not applicable.

b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

This criterion is not applicable.

3. For renovation or expansions of an existing licensed health care institution:

a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

The applicant has proposed this project due to the current high surgical volume and the projected future growth of surgical patients who will continue to access subspecialty surgical care. Patients from an extended service area and out-of-state seek surgical care from Vanderbilt. Vanderbilt surgical case volume currently performed at the Nashville Surgery Center will be relocated to Vanderbilt in October 2014, resulting in approximately 3,000 additional cases. (The applicant is a 40% minority owner in Nashville Surgery Center). VUH is projecting 38,600 surgical cases by 2017.

b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

The proposed project is immediately adjacent to existing surgical service and the all the major resources committed to surgical care at VUH. The expansion will improve patient flow and care coordination by utilizing existing services.